



## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### 42 CFR Chapter I

#### Mandatory Guidelines for Federal Workplace Drug Testing Programs

**AGENCY:** Substance Abuse and Mental Health Services Administration (SAMHSA),  
Department of Health and Human Services (HHS).

**ACTION:** Notification of mandatory guidelines.

**SUMMARY:** The Department of Health and Human Services (“HHS” or “Department”) is proposing to revise the Mandatory Guidelines for Federal Workplace Drug Testing Programs using Urine (UrMG), which published in the **Federal Register** of January 23, 2017.

**DATES:** Submit comments on or before **[INSERT DATE 60 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]**.

**ADDRESSES:** In commenting, please refer to file code SAMHSA 2022-0001. Because of staff and resource limitations, SAMHSA cannot accept comments by facsimile (fax) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

•*Electronically.* You may submit electronic comments on this document to <https://www.regulations.gov>. Follow “Submit a comment” instructions.

•*By regular mail.* You may mail written comments to the following address: SAMHSA, Center for Substance Abuse Prevention (CSAP), Division of Workplace Programs (DWP), 5600 Fishers Lane, Room 16N02, Rockville, MD 20857. Please allow sufficient time for mailed comments to be received before the close of the comment period.

•*By express or overnight mail.* You may send written comments to the following address:

SAMHSA, CSAP, DWP, 5600 Fishers Lane, Room 16N02, Rockville, MD 20857.

•*By hand or courier.* You may deliver your written comments by hand or courier to the following address prior to the close of the comment period: SAMHSA, CSAP, DWP, 5600 Fishers Lane, Room 16N02, Rockville, MD 20857. If you intend to deliver your comments to the Rockville address, please call (240) 276-2600 in advance to schedule your arrival with one of our staff members. Because access to the SAMHSA building is secure, persons without Federal Government identification are encouraged to schedule their delivery or to leave comments with the security guard at the front desk located in the main lobby of the building.

All comments received before the close of the comment period will be available for viewing by the public. Please note that all comments are posted in their entirety, including personal or confidential business information that is included in the comment. SAMHSA will post all comments before the close of the comment period on the following website:

<https://www.regulations.gov>. Use the website's search function to view the associated comments.

Comments received before the close of the comment period will also be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, at SAMHSA, CSAP, DWP, 5600 Fishers Lane, Rockville, MD 20857, Monday through Friday of each week, excluding Federal holidays, from 8:30 a.m. to 4:00 p.m. To schedule an appointment to view public comments, please call (240) 276-2600.

**FOR FURTHER INFORMATION CONTACT:** Eugene D. Hayes, PhD, MBA, SAMHSA, CSAP, DWP; 5600 Fishers Lane, Room 16N02, Rockville, MD 20857, by telephone (240) 276-1459 or by email at [Eugene.Hayes@samhsa.hhs.gov](mailto:Eugene.Hayes@samhsa.hhs.gov).

**SUPPLEMENTARY INFORMATION:**

## Executive Summary

This notification of proposed revisions to the Mandatory Guidelines for Federal Workplace Drug Testing Programs using Urine (UrMG) includes revisions that will: establish a process whereby the Department annually publishes the authorized drug testing panel (i.e., drugs, analytes, and cutoffs) to be used for Federal workplace drug testing programs; revise the definition of a substituted specimen to include specimens with a biomarker concentration inconsistent with that established for a human specimen; establish a process whereby the Department publishes an authorized biomarker testing panel (i.e., biomarkers, analytes, and cutoffs) for Federal workplace drug testing programs; revise the confirmatory test cutoff for morphine; revise the Medical Review Officer (MRO) verification process for positive codeine and morphine specimens; and require MROs to submit semiannual reports to the Secretary or designated HHS representative on Federal agency specimens that were reported as positive for a drug or drug metabolite by a laboratory and verified as negative by the MRO. In addition, some wording changes have been made for clarity and for consistency with the Mandatory Guidelines for Federal Workplace Drug Testing Programs using Oral Fluid (OFMG), 84 FR 57554 (October 25, 2019), or to apply to any authorized specimen type.

The Department is publishing a separate Federal Register Notification (FRN) elsewhere in this issue of the **Federal Register** proposing revisions to the OFMG, including the same or similar revisions proposed for the UrMG, where appropriate.

## Background

The Department of Health and Human Services, pursuant to the Department's authority under Section 503 of Public Law 100-71, 5 U.S.C. Section 7301, and Executive Order 12564, establishes the scientific and technical guidelines for Federal workplace drug testing programs and establishes standards for certification of laboratories engaged in drug testing for Federal

agencies. Using data obtained from the Federal Workplace Drug Testing Programs and HHS-certified laboratories, the Department estimates that 275,000 urine specimens are tested annually by Federal agencies.

As required, HHS originally published the Mandatory Guidelines for Federal Workplace Drug Testing Programs (Guidelines) in the **Federal Register** (FR) on April 11, 1988 (53 FR 11979). The Substance Abuse and Mental Health Services Administration (SAMHSA) subsequently revised the Guidelines on June 9, 1994 (59 FR 29908), September 30, 1997 (62 FR 51118), November 13, 1998 (63 FR 63483), April 13, 2004 (69 FR 19644), and November 25, 2008 (73 FR 71858). SAMHSA published the current Mandatory Guidelines for Federal Workplace Drug Testing Programs using Urine (UrMG) on January 23, 2017 (82 FR 7920), and HHS published the current Mandatory Guidelines for Federal Workplace Drug Testing Programs using Oral Fluid (OFMG) on October 25, 2019 (84 FR 57554).

## **Proposed Revisions to the HHS Mandatory Guidelines for Federal Workplace Drug Testing Programs**

### *Authorized drug testing panel*

The Guidelines pertain to a matter of Federal agency personnel and, therefore, are not subject to the notice and comment procedures under the Administrative Procedures Act. In light of the potential impact on entities outside of the Federal Government, the Department has chosen to submit the Guidelines to notice and comment, and will continue to do so. In this revision, the Department is proposing to change the way a specific part of the Guidelines (i.e., the drug testing panel) is published and the frequency with which it is published.

Since the original Guidelines were published in 1988, several recommendations have been made for drugs to be added to or removed from Federal workplace drug testing programs.

The Department has revised the Guidelines in the past to add or remove drugs from the authorized drug testing panel and to revise test cutoffs (i.e., Section 3.4 of the UrMG). The time required to revise the Guidelines through the Federal review process has impeded the Department's ability to respond to drug use trends. Individuals may change their drug use, and illicit drug manufacturers may change their manufacturing methods, to avoid testing positive for drugs included in proposed Guidelines, especially as the number of new drugs and drug analogues increases. A less flexible drug testing panel may delay needed drug analyte or cutoff changes based on the state of the science (e.g., new technologies, research including dosing studies). Therefore, the Department proposes to publish the drug testing panel in the **Federal Register** on at least an annual basis, including any revisions to the panel, without the need (perceived or otherwise) to undergo notice and comment. Should the Department remove a drug from the drug testing panel, a Federal agency may test specimens for that drug in accordance with Section 3.2 (i.e., on a case-by-case basis for reasonable suspicion or post accident testing, or routinely with a waiver from the Secretary). This process is expected to improve the effectiveness of Federal agency drug testing programs in support of the Federal Drug-Free Workplace Program. The drug testing panel in Section 3.4 of the final UrMG will remain in effect until the Department publishes a separate FRN with the drug testing panel.

The Department will continue to monitor drug use trends and review information on new drugs of abuse from sources such as Federal regulators, researchers, the drug testing industry (including HHS-certified laboratories), and public and private sector employers, to determine whether drugs should be added or removed from the panel. Any changes to analytes and cutoffs made in accordance with the newly established drug testing panel publishing process will be based on a thorough review of relevant information, including the current state of the science, laboratory capabilities, cost associated with the change, and benefits of the change to Federal agencies. The Department will set a date for the panel changes to take effect and include the effective date in the annual drug testing panel FRN in order to allow time for drug testing service

providers (e.g., immunoassay kit manufacturers) to develop or revise their products, and for HHS-certified laboratories to develop or revise assays, complete validation studies, and revise procedures. The prior version of the panel will remain in effect until the effective date of a newly published annual panel.

For consistency and to avoid misinterpretation of drug test results, the Department is requiring HHS-certified laboratories and HHS-certified instrumented initial test facilities (collectively referred to hereafter as “HHS-certified test facilities”) and Medical Review Officers (MROs) to report results using the nomenclature (i.e., analyte names and abbreviations) published with the drug testing panel.

#### *Authorized biomarker testing panel*

A biomarker is an endogenous substance used to validate a biological specimen. The purpose of a biomarker test is to determine whether a submitted specimen is a human specimen. The current UrMG (effective October 1, 2017) allow additional specimen validity testing using biomarkers upon MRO request, to provide information to assist the MRO in the verification process. The current UrMG also require HHS-certified laboratories to report a specimen as invalid when the biomarker is not present or when its concentration is not consistent with that established for human urine but does not allow these specimens to be reported as substituted. The Department proposes to revise the UrMG to define such specimens as substituted, and to allow only biomarker tests that have been authorized by SAMHSA for use in Federal agency workplace drug testing programs.

To ensure that scientifically valid biomarker tests, analytes, and cutoffs are standardized for Federal workplace drug testing, the Department will institute an approval process for biomarker tests, based on review of data from the scientific and/or medical literature, before authorizing the use of the biomarker test. This process is equivalent to the approval process

currently in use for testing additional Schedule 1 and 2 drugs or adding new tests for a specific adulterant. The Department will accept scientific information submitted for review from various sources (e.g., HHS-certified test facilities, drug testing industry stakeholders, researchers). The Department will include the authorized biomarker testing panel (i.e., a table of biomarkers authorized for testing, with test analytes and cutoffs), in the FRN to be published annually (as described earlier in this preamble). Federal agencies may choose to test some or all of their workplace specimens for one or more authorized biomarkers.

An HHS-certified laboratory, or (for urine only) an HHS-certified instrumented initial test facility (IITF), may request authorization from SAMHSA to conduct a biomarker test that has not been included on the list of authorized biomarkers. The test facility must submit supporting documentation and assay validation records to the National Laboratory Certification Program (NLCP) for SAMHSA review and approval. When a urine biomarker test is approved through this process, SAMHSA will authorize the individual HHS-certified test facility to perform the biomarker test for federally regulated specimens only upon MRO request (i.e., a blanket request for all specimens or a case-by-case request for a specific specimen). A certified laboratory or IITF may choose to begin the process by submitting supporting documentation for review prior to assay validation, or may send supporting documentation with completed validation records. The Department will continue to include measurands and decision points for other specimen validity tests in the UrMG (e.g., Sections 11.19 and 12.15).

Once a biomarker test has been added to the authorized biomarker panel published in the FRN, any HHS-certified laboratory or IITF may routinely conduct the test without requiring an MRO request, and only require a signed MRO request for case-by-case biomarker testing (in accordance with UrMG section 3.5). The Department will continue to require NLCP review of biomarker assay validation records before allowing an IITF or laboratory to use the test for federally regulated workplace specimens.

This process will facilitate the identification of donors who attempt to subvert their drug test, and ensure that biomarker tests used for federally regulated workplace programs are scientifically supportable and properly validated, and that all HHS-certified test facilities use the same analytes and cutoffs.

For consistency and to avoid misinterpretation of biomarker test results, the Department is requiring HHS-certified test facilities and Medical Review Officers (MROs) to report results using the nomenclature (i.e., analyte names and abbreviations) published with the biomarker testing panel.

#### *Medical Review Officer (MRO) verification of codeine and morphine test results*

The MRO has an essential role in federally regulated workplace drug testing programs that includes performing the review of laboratory results and supporting documentation, interviewing the donor when necessary, and making a final determination regarding the result. As described in Section 13.5d(2) of the current UrMG, when a donor has no legitimate medical explanation for a positive codeine or morphine result equal to or greater than 15,000 ng/mL, the MRO reports the specimen as positive to the agency. When a donor has no legitimate medical explanation for a positive codeine or morphine result less than 15,000 ng/mL, the MRO must determine that there is clinical evidence of illegal opioid use (in addition to the test results) to report such specimens as positive. If the MRO finds no clinical evidence of illegal opioid use, the MRO verifies the opiate results as negative. These requirements were included in the UrMG to address positive codeine and/or morphine results that may be due to poppy seed ingestion. The Department proposes to remove the additional decision point for codeine and morphine, to adjust the confirmatory test cutoff for morphine from 2,000 to 4,000 ng/mL, and to remove the additional requirement for clinical evidence of illegal opioid use, as described above. The

confirmatory test cutoff for codeine will remain at 2,000 ng/mL. The basis for the Department's proposed changes is described in the following paragraphs.

A review of the scientific literature, as cited below, regarding the role of poppy seed food products in producing positive urine drug tests for the opiates, codeine and morphine, was undertaken to ascertain whether the current decision point should be maintained or changed. The Department focused on studies using analytical techniques acceptable to modern forensic toxicology laboratories, for which the researchers included information on poppy seed doses and adequately described the analytical techniques. Because most common poppy variants produce morphine in great excess to codeine, morphine concentrations significantly exceeded codeine concentrations in all reviewed studies.

Studies of patients being tested for abstinence from heroin use suggest that urine concentrations of morphine are often below 15,000 ng/mL and the heroin metabolite, 6-acetylmorphine (6-AM) is absent, indicating the heroin use was not within the short detection limit for 6-AM. A study by Colby et al. examined morphine concentrations in urine specimens from chronic pain patients being monitored for medication compliance. Patients with positive 6-AM results had morphine concentrations averaging 85,000 ng/mL ( $\pm$  154,000 ng/mL), with 25% at or below 10,000 ng/mL and an additional 15% falling between 10,000 ng/mL and 20,000 ng/mL. (Ref. 1) However, it is well known that 6-AM is generally positive in only the first few urine specimens following heroin dosing, making it the limiting factor in unequivocal detection of heroin use. (Ref. 2 and 3) Further, in a study by Wang et al., heroin metabolites including morphine were measured in subjects seeking in-patient addiction treatment for heroin use. In 20 subjects without 6-AM positive urine specimens, the total morphine concentration ranged from 87 to 34,896 ng/mL and averaged 9,960 ng/mL. Only 30% of the subjects had specimens above the 15,000 ng/mL decision point specified by the current UrMG. Lowering the morphine cutoff to 4,000 ng/mL would identify another 30% of the heroin users in this type of cohort. (Ref. 4)

In regard to poppy seed food products, the literature is consistent in the conclusion that regular ingestion of poppy seed-containing foods (bagels, cakes, curries, etc.) rarely results in urine opiate concentrations above the 2,000 ng/mL cutoff specified in the current UrMG, and that proper handling by pre-washing and cooking the poppy seeds into food products causes loss of both morphine and codeine. Studies attempting to characterize morphine and codeine results after reasonable consumption of poppy seed food products on an acute and chronic basis reported maximum morphine concentrations ranging between 160 and 3,000 ng/mL with codeine ranging between 11 and 390 ng/mL. (Ref. 3 and 5-8) There is only one study in which the urine concentration of morphine exceeded 4,000 ng/mL after ingestion of regular prepared food containing poppy seeds, and the researchers reported that some subjects became ill due to the large amount of poppy seeds in the food product. (Ref. 9) The results of this study have not been duplicated in subsequent studies involving prepared food products.

Other studies used extreme exposure protocols involving intolerable or near intolerable amounts of raw and/or unwashed poppy seeds, which are known to contain much more codeine and morphine than their washed and cooked counterparts. In one such extreme study in 2015, the researchers reported that participants felt that 15 g of raw, unwashed poppy seeds was close to the bearable limit for ingestion, and the maximum urine concentration was 4,200 ng/mL for morphine and 664 ng/mL for codeine. (Ref. 7) Of note, this study also included the same dose of poppy seeds baked in a roll and maximum morphine and codeine concentrations were considerably lower at 1,400 and 194 ng/mL, respectively. This research confirms the results of extreme ingestion by three volunteers in a 2003 study by Rohrig and Moore, and the experience in a 2014 study by Smith et al. in which only 19 of 22 participants could tolerate ingestion of all planned doses. (Ref. 10 and 11) Further, in the 2014 study, seven of the 19 subjects did not produce a positive morphine result (i.e.,  $\geq 2,000$  ng/mL) until after the second extreme dose of poppy seeds, approximately eight hours after the first dose. At all times in this study, codeine results were below the 2,000 ng/mL cutoff. The Department finds these studies relevant to

setting the cutoff limit of 4,000 ng/mL for morphine and sufficient for eliminating positives due to poppy seeds because they confirm that urine morphine concentrations exceeding 4,000 ng/mL would be very rare, transient, and a consequence of unrealistic and extreme poppy seed exposure (i.e., ingesting barely tolerable amounts of raw and/or unwashed poppy seeds).

The Department also reviewed information on other sources of poppy seed exposure. In reaction to at least 12 deaths reported in the scientific literature associated with the use of tea prepared with unwashed poppy seeds and the availability of unwashed poppy seeds from online retailers, the Drug Enforcement Administration (DEA) issued a warning in 2019 restating that unwashed poppy seeds are a danger to the user, and their use and misuse may result in unpredictable outcomes including death when used alone or in combination with other drugs. DEA reiterated that the morphine and codeine, if present as contaminants on poppy seed material, are not exempted from the Controlled Substances Act (CSA) control. (Ref. 12)

In summary, the Department is not aware of any evidence that reasonable or realistic consumption of poppy seed-containing food products would cause a positive drug test using the codeine and morphine cutoffs specified by these Guidelines. Only purposeful consumption of large amounts (e.g., 15 g or more) of raw and/or unwashed poppy seeds has been shown to result in codeine at or above 600 ng/mL or in morphine exceeding 4,000 ng/mL, and the extreme amounts of poppy seeds in these studies, described by subjects as intolerable or barely tolerable, do not represent a real-world situation for donors in a Federal agency testing program.

Based on this information, the Department has decided that no additional decision point is needed for MRO verification of codeine and morphine results. Further, the Department has concluded that continued use of the current 15,000 ng/mL decision point diminishes the deterrent effect of the program by attributing codeine and morphine results between the cutoff and 15,000 ng/mL to poppy seed ingestion in the absence of a legitimate medical explanation. The Department proposes to raise the confirmatory test cutoff for morphine to 4,000 ng/mL to rule

out any donor claims that consumption of poppy seed food products (on an acute or chronic basis) was the reason for a positive morphine test result. This cutoff change makes the Federal drug testing program cutoffs for codeine and morphine the same as the Department of Defense (DoD) program cutoffs, which were previously raised to these concentrations to eliminate positive tests due to poppy seeds. (Ref. 14)

#### *Medical Review Officer (MRO) semiannual reports*

The Department, through the NLCP, obtains information from HHS-certified laboratories that is reviewed to verify accurate reports and compliance with Guidelines requirements. The NLCP conducts statistical analysis and provides reports to the Department on federally regulated workplace testing, although the data are limited to laboratory-reported results and not the final, MRO-verified results. To obtain additional information needed to assess compliance with the Mandatory Guidelines, the Department proposes to require each MRO performing medical review services for Federal agencies to submit semiannual reports, in January and July of each year, of Federal agency specimens that were reported as positive for a drug or drug metabolite by the laboratory, and verified as negative by the MRO, along with the reason for the negative verification (e.g., a valid prescription for a drug). The reports will not contain any personally identifiable information of the donors.

This revision to the Guidelines will enable Department oversight of MRO reporting practices and will enhance the Department's ability to verify the accuracy of MRO reports and address areas of confusion about Guidelines requirements. The information in the MRO reports will be matched to information submitted to the NLCP by HHS-certified laboratories for the same specimens. This additional information will improve statistical analyses and provide a clearer picture of illicit drug use by Federal job applicants and employees.

#### **Proposed Revisions to the Guidelines**

This preamble describes the proposed revisions to the Mandatory Guidelines for Federal Workplace Drug Testing Programs using Urine (UrMG), and the rationale for the changes.

### **Subpart A – Applicability**

Section 1.5 defines terms used in the UrMG. The Department has added terms and revised definitions in this section in accordance with proposed changes to these Guidelines, and to standardize terms and definitions, where possible, to apply to all authorized specimen types.

The Department proposes to revise the Substituted Specimen definition to include specimens tested for a biomarker, when the biomarker is absent or is present at a concentration inconsistent with that established for a human specimen. For clarity, the Department also added a reference to the reporting criteria for substitution in Section 3.7 of these Guidelines. For clarity and consistency with the revised Substituted Specimen definition, the Department proposes to edit the Adulterated Specimen definition to apply to specimens with “an abnormal concentration of a normal constituent (e.g., nitrite in urine),” rather than “an abnormal concentration of an endogenous substance,” and to revise definitions for Cutoff and Initial Specimen Validity Test to remove the “(for urine)” specification for identifying a substituted specimen. The Department proposes to revise the Collection Container definition to apply to all authorized specimen types, by changing “a urine specimen” to “a donor’s drug test specimen.” The Department has also added definitions for “Biomarker Testing Panel” and “Drug Testing Panel” consistent with the proposed publication of these testing panels in a separate FRN each year.

Section 1.7 describes what constitutes a donor’s refusal to take a federally regulated drug test. Section 1.7(a) includes exceptions for a donor who fails to appear in a reasonable time for a pre-employment test and a donor who leaves the collection site before the collection process begins for a pre-employment test. The Department finds that there is no justification for altering a refusal to test based on whether the test is being conducted in the employment or pre-employment context and, therefore, proposes to remove these exceptions. The collector will

report a refusal to test for any donor who fails to appear in a reasonable time or who leaves the collection site before the collection is complete, regardless of the reason for the test.

Section 1.8(a) describes the potential consequences for a refusal to test. The Department has reworded this section to clarify potential actions for a Federal employee who refuses to take a drug test, and the potential action for an applicant who refuses to take a pre-employment test.

### **Subpart C – Urine Specimen Tests**

The Department proposes to edit Section 3.1 to reflect the proposed process for publishing drug and biomarker testing panels in an FRN each year containing a list of authorized drug analytes and biomarkers that can be tested. As described under *Authorized drug testing panel* and *Authorized biomarker testing panel* above, the time required to revise the Guidelines through the Federal review process has impeded the Department's ability to respond to drug use trends, and to make drug analyte or cutoff changes based on the state of the science (e.g., new technologies, research including dosing studies). This new process is expected to improve the effectiveness of Federal agency drug testing programs in support of the Federal Drug-Free Workplace Program. See also Section 3.4.

For clarity, the Department also revised the header for Section 3.2 to refer to “drugs other than those in the drug testing panel” (see above) rather than “additional drugs”.

The Department has revised the analytes and cutoffs table in Section 3.4 of the UrMG to reflect the proposed change to the confirmatory cutoff for morphine, and revised the section to describe the publication of a final notification in the **Federal Register** each year that will include the authorized drugs, test analytes, and cutoffs; the authorized biomarkers, test analytes, and cutoffs; and the nomenclature required for IITF, laboratory, and MRO reports. The annual notification will be posted on the SAMHSA website, <https://www.samhsa.gov/workplace>. The

table in Section 3.4 of the final UrMG will remain in effect until the effective date of the new panels published in the separate FRN.

Section 3.7 describes the criteria used to report a specimen as substituted and Section 3.9 describes the criteria used to report an invalid result for a urine specimen. The current sections require laboratories to report a specimen as invalid when a biomarker is not present or its concentration is outside the range established for that biomarker in human urine. As described under *Authorized biomarker testing panel* above, the purpose of a biomarker test is to determine whether a submitted specimen is a human specimen. Therefore, the Department proposes to revise these sections to require specimens to be reported as substituted, rather than invalid, based on biomarker testing. See also Section 1.5.

#### **Subpart H – Urine Specimen Collection Procedure**

The Department proposes to revise the wording in Section 8.3(f) regarding how instructions for completing the Federal Custody and Control Form (CCF) are provided to the donor. This is consistent with changes made to the Federal CCF to enable its use with both urine and oral fluid specimens.

The Department moved items under Section 8.3(h) into a new item 8.3(i) addressing the collector's request for the donor to display the contents of their pockets and subsequent collector actions. The required actions remain the same, but the Department revised wording in new items 8.3(i)(1) through 8.3(i)(4) for clarity.

In Section 8.5(a), the Department clarified that the collector must inform the donor that the donor's failure to remain at the collection site until the collection is complete will be reported as a refusal to test. This is consistent with Section 1.7.

The Department also revised wording in Section 8.9(a)(3) for clarity.

#### **Subpart I - HHS Certification of Laboratories and IITFs**

Section 9.7 describes performance test (PT) requirements for an HHS-certified laboratory and Section 9.9 describes PT requirements for an HHS-certified IITF. PT error criteria will remain the same; however, the Department is proposing to edit some items for clarity. Specifically, the Department proposes to revise Sections 9.7(a)(5), 9.7(a)(10), and 9.9(a)(6) to state clearly that quantitative values reported for drug and specimen validity tests are evaluated based on reported results for each PT cycle, not on cumulative results reported over two consecutive PT cycles. An HHS-certified test facility must not obtain a quantitative value outside the specified range for a drug or specimen validity test result, based on the appropriate reference or peer group mean.

The Department also revised Section 9.6(a)(11) for an applicant laboratory and Section 9.7(a)(10) for an HHS-certified laboratory to address requirements for PT samples reported as substituted based on biomarker test results, in addition to those reported as substituted based on creatinine and specific gravity test results.

## **Subpart K- Laboratory**

Section 11.19 describes the requirements for an HHS-certified laboratory to report primary (A) specimen test results to an MRO. The Department proposes to revise the requirements for reporting a specimen as substituted in item 11.19(e) to include specimens with a biomarker concentration inconsistent with that established for human urine, in addition to those reported as substituted based on creatinine and specific gravity test results (see also Sections 1.5, 3.7, and 3.9).

Section 11.19(g) addresses laboratory and MRO discussions to determine whether additional testing may be useful for specimens with certain invalid results. Because biomarker testing could be used to identify substitution, the Department has revised this section to indicate

that additional testing may be useful in being able to report a substituted result, as well as positive or adulterated results.

Section 11.19(g) describes the requirements for a laboratory to report a specimen as invalid. The Department has added an item 13 addressing tests used to determine specimen validity, other than those specifically listed in this section.

The Department also proposes to add a new item 11.19(m) stating that the laboratory must use the HHS-specified nomenclature published with the drug and biomarker testing panels on reports. This change is to ensure consistency in reporting and interpretation of test results, by requiring the results of each test performed to be reported using clear and correct nomenclature for test analytes, with the same terminology and units of measurement. See also Section 3.4.

#### **Subpart L – Instrumented Initial Test Facility (IITF)**

Section 12.15 describes the requirements for an HHS-certified IITF to report primary (A) specimen test results to an MRO. The Department proposes to add a new item 12.15(e) stating that the IITF must use the HHS-specified nomenclature published with the drug and biomarker testing panels on reports. See also Section 3.4.

#### **Subpart M - Medical Review Officer (MRO)**

Section 13.4(f) describes when an MRO must conduct a medical examination or review an examining physician's findings when the collector reported that the donor was unable to provide a specimen. The Department has clarified that a medical examination is not required when an alternate specimen was collected.

Section 13.5(c)(2) describes MRO actions when a laboratory reports an invalid result in conjunction with a positive, adulterated, or substituted result. The Department has added an item to this section to clarify that the MRO takes the required action for the invalid result (specified in

item f of this section) only when the MRO has verified the other result(s) for the specimen (i.e., positive, adulterated, or substituted) as negative or when the split (B) specimen was tested and reported as a failure to reconfirm.

Section 13.5(d) describes MRO actions to determine whether the donor has a legitimate medical explanation for a positive specimen test result. The Department added a new item Section 13.5(d)(1) to clarify that the MRO reports a positive result when the donor admits unauthorized use of the drug(s) that caused the positive test result, and documents the admission of unauthorized use in the MRO records and in the MRO's report to the Federal agency. A donor's admission of unauthorized use corroborates the positive test.

Currently, Section 13.5(d)(2) includes the policies of the Department that passive exposure to marijuana smoke and ingestion of food products containing marijuana are not acceptable medical explanations for a positive marijuana test result. The Department proposes to reword this section to clarify that these policies apply to any positive urine drug test results, not only positive marijuana results. Item i of this section now states that passive exposure to any drug is not an acceptable medical explanation for a positive drug test, with "exposure to secondhand marijuana smoke" as an example of passive exposure. Item ii of this section now states that ingestion of food products containing a drug is not an acceptable medical explanation for a positive drug test, with "products containing marijuana" and "poppy seeds containing codeine and/or morphine" as examples. The Department also proposes to add a new item iii to this section stating that a physician's authorization or medical recommendation for a Schedule I substance is not an acceptable medical explanation for a positive drug test. Under the CSA, a Schedule I substance is defined as a drug, chemical, or other substance with no currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse. (Ref. 13) The DEA maintains the current listing of controlled substances on their website.

Section 13.5(d)(3) describes MRO actions when the donor has no legitimate medical explanation for a positive drug test result. The Department has revised this section to remove the exceptions for codeine and morphine. As described above under *MRO verification of codeine and morphine test results*, the Department has removed the additional 15,000 ng/mL decision point for codeine and morphine, as well as the requirement for the MRO to report such specimens as positive based on clinical evidence of illicit drug use (in addition to the drug test results). The MRO will follow the same verification procedures for all specimens with positive test results.

Section 13.9 describes how an MRO reports primary (A) drug test results to an agency. The Department proposes to add a new item 13.9(e) stating that the MRO must use the HHS-specified nomenclature published with the drug and biomarker testing panels on reports. See also Section 3.4.

The Department has included a new Section 13.11 describing the proposed requirement for an MRO to send semiannual reports to the Secretary or designated HHS representative for Federal agency specimens that were reported as positive by a laboratory and verified as negative by the MRO. As described under *Medical Review Officer (MRO) semiannual reports* above, this change will enable Department oversight of MRO practices and will enhance the Department's ability to verify the accuracy of MRO reports and address areas of confusion about Guidelines requirements. In addition, the information in the MRO reports will be matched to information submitted to the NLCP by HHS-certified laboratories for the same specimens, thereby improving statistical analyses and providing a clearer picture of illicit drug use by Federal job applicants and employees. The reports must not include any personally identifiable information for the donor, and must be submitted within 14 working days after the end of the semiannual period (i.e., in July and January). Section 13.11 lists the information that must be included on the reports. To facilitate report preparation and review, the Department will include a template for

these MRO reports in the MRO Guidance Manual and will arrange a secure method for MROs to submit reports electronically.

The Department has included a new Section 13.12 describing the Federal agency's responsibilities for designating an MRO. These responsibilities include verifying and documenting that individuals meet the MRO requirements in these Guidelines before allowing them to serve as an MRO for the agency's drug testing program and on an ongoing basis, and ensuring that each MRO reports drug test results in accordance with the Guidelines. Further, the Federal agency must obtain documentation from the MRO to confirm that the MRO and any external service provider ensures the confidentiality integrity and availability of the data and limits the access to any data transmission, storage, and retrieval system.

#### **Subpart N - Split Specimen Tests**

Section 14.4 describes how an HHS-certified laboratory reports a split (B) urine specimen when the primary (A) specimen was reported substituted. The Department proposes to revise this section to address primary (A) specimens reported as substituted based on biomarker test results, in addition to those reported as substituted based on creatinine and specific gravity test results. See also Section 1.5.

Section 14.5 states that the HHS-certified laboratory that tested a split (B) specimen must report the results to the MRO. The Department proposes to reword this section to require the laboratory to use the HHS-specified nomenclature published with the drug and biomarker testing panels on reports for split (B) specimens. See also Section 3.4.

Section 14.6 describes the actions an MRO takes after receiving a split (B) urine specimen result from an HHS-certified laboratory. Section 14.6(c) specifies MRO actions when the laboratory failed to reconfirm one or more positive results and reported the split specimen as substituted. The Department proposes to revise this item to address actions when the B specimen

was reported as substituted based on biomarker test results, in addition to those reported as substituted based on creatinine and specific gravity test results. See also Section 1.5. The Department also proposes to add a new item 14.6(k) to address MRO verification of split (B) specimen results when the B specimen fails to reconfirm adulteration or substitution and is invalid.

Section 14.7 describes how an MRO reports split (B) specimen test results to an agency. The Department proposes to add a new item 14.7(e) stating that the MRO must use the HHS-specified nomenclature published with the drug and biomarker testing panels on reports. See also Section 3.4.

### **General revisions**

In addition to the proposed changes described by subpart and section above, the Department has edited the UrMG to address proposed changes (e.g., removing “for urine” when referring to substituted specimens; referencing the proposed annual FRN with drug and biomarker testing panels) and has reworded some items for clarity and/or for consistency with the OFMG.

### **Impact of These Guidelines on Government Regulated Industries**

The proposed revised Guidelines may impact the Department of Transportation (DOT) and Nuclear Regulatory Commission (NRC) regulated industries depending on these agencies’ decisions to incorporate the final UrMG revisions into their programs under their own authority.

### **Costs and Benefits**

#### *Costs*

The proposed UrMG revision to publish the drug testing panel in a separate FRN each year (e.g., Section 3.4) may result in a cost increase for HHS-certified test facilities and MROs (e.g., costs for test supplies, assay validation, administrative changes) when a new drug is added

to the panel or when analytes or cutoffs are changed for current drugs. The added costs will depend on the change. For example, implementation costs would be lower for laboratories that already offer the drug test or use the different analyte or cutoff for their non-regulated clients. MROs may experience increased costs when an agency chooses to test their Federal job applicants and employees for a new authorized drug with a high positivity rate or a Schedule II drug requiring the MRO to review medical explanations. Additional costs for testing and MRO review will be incorporated into the overall cost for the Federal agency submitting the specimen to the laboratory. Added costs to MROs would be expected to shift to Federal agencies over time, as existing contracts expire and new contract terms are negotiated. As noted earlier in this preamble, the Department will consider costs when deciding whether to make a change to the authorized drug tests. At this time, the Department will not require HHS-certified test facilities to implement authorized biomarker tests. Each laboratory and IITF should conduct their own cost analysis when deciding whether to offer biomarker testing to federally regulated clients. The Department will consider costs when deciding whether to require all certified test facilities to test for a specific biomarker.

The proposed change to the morphine confirmatory test cutoff from 2,000 ng/mL to 4,000 ng/mL will result in some initial costs for HHS-certified laboratories (e.g., to revalidate their opiate confirmatory assays, revise opiate calibrators and controls, and revise review and reporting procedures). However, there should also be some cost savings as described below under *Benefits*.

There will be some administrative costs for MROs associated with the generation and submission of the semiannual reports of verified-negative results (see Section 13.11). The Department encourages the use of electronic recordkeeping to facilitate information retrieval and report generation, and will enable secure submission of electronic information to reduce MRO costs to provide these reports.

## *Benefits*

The potential benefits of more timely changes to the drug testing panel will result in a healthier and more productive workforce, as well as avoid the issues associated with addiction and rehabilitation. Since the personnel tested under this program are in positions that are safety sensitive, potential benefits include decreased risk of transportation and workplace accidents, decreased risk of low-probability high consequence events, a more responsible workforce in positions of public trust, and potentially reducing individuals' dependence on addiction and the personal benefits associated with those conditions. Considering the potential health and performance costs of drug misuse, the benefits to the Federal workplace and the individuals within that workplace justify the more agile method of changing the drug testing panel for the Federal workplace drug testing programs.

The number of commercial substitution and adulteration products aimed at defeating a drug test continues to proliferate for both urine and oral fluid. Manufacturers alter their existing products or develop new products to subvert drug and specimen validity tests in federally regulated workplace programs. (Ref. 15 and 16) When the Department added provisions for biomarker testing in the current UrMG, the intent was to identify non-human urine samples that were submitted for testing in place of the donor's urine. The proposed revision to report a specimen as substituted (not invalid) based on biomarker testing is consistent with this intention. This revision, as well as the Department review and approval of biomarker tests and the added flexibility for making changes to the drug and biomarker testing panels, will strengthen the Federal Government's ability to identify illicit drug use and donor attempts to subvert drug tests.

The proposed requirement for semiannual MRO reports on laboratory-positive/MRO-negative results will enable the Department to ensure accurate reports and MRO compliance with Guidelines requirements. The information in the MRO reports will be matched to information

for the same specimens that was submitted to the NLCP by the HHS-certified laboratory, thereby improving statistical analyses and providing a clearer picture of illicit drug use by Federal job applicants and employees.

As noted above under *Costs*, HHS-certified laboratories will incur some initial costs for changing the morphine confirmatory test cutoff; however, laboratories will also experience some benefits in that the removal of the 15,000 ng/mL decision points for codeine and morphine will simplify codeine and morphine review and reporting procedures. MROs may also experience some savings, as the removal of the decision points and clinical evaluation requirement for some codeine and morphine positive results will simplify the MRO verification process. That is, codeine and morphine positive results will be reviewed and verified using the same procedures as positive results for other drugs.

### **Information Collection/Record Keeping Requirements**

The information collection requirements (i.e., reporting and recordkeeping) in the current Guidelines, which establish the scientific and technical guidelines for Federal workplace drug testing programs and establish standards for certification of laboratories engaged in urine drug testing for Federal agencies under authority of 5 U.S.C. 7301 and Executive Order 12564, are approved by the Office of Management and Budget (OMB) under control number 0930-0158. The Federal Drug Testing Custody and Control Form (Federal CCF) used to document the collection and chain of custody of urine and oral fluid specimens at the collection site, for laboratories to report results, and for Medical Review Officers to make a determination; the National Laboratory Certification Program (NLCP) application; the NLCP Laboratory Information Checklist; and recordkeeping requirements in the current Guidelines, as approved under control number 0930-0158, will remain in effect.

In support of the Government Paperwork Reduction Act (PRA), the Department revised the Federal CCF to enable its use as an electronic form (78 FR 42091, July 15, 2013) and

developed requirements and oversight procedures to ensure that HHS-certified test facilities and other service providers (e.g., collection sites, MROs) using an electronic version of the Federal CCF (ECCF) maintain the accuracy, security, and confidentiality of electronic drug test information. Before a Federal ECCF can be used for Federal agency specimens, HHS-certified test facilities must submit detailed information and proposed standard operating procedures (SOPs) to the NLCP for SAMHSA review and approval, and undergo an NLCP inspection focused on the proposed ECCF.

Since 2013, SAMHSA has encouraged the use of Federal ECCFs and other electronic processes in HHS-certified test facilities, when practicable, for federally regulated testing operations. In accordance with Section 8108(a) of the SUPPORT for Patients and Communities Act, SAMHSA has set a deadline of August 31, 2023, for all HHS-certified laboratories to submit a request for approval of an electronic (paperless) Federal CCF.

The title and description of the information collected and respondent description are shown in the following paragraphs with an estimate of the annual reporting, disclosure, and recordkeeping burden. Included in the estimate is the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

*Title:* The Mandatory Guidelines for Federal Workplace Drug Testing Programs using Urine

*Description:* The Mandatory Guidelines establish the scientific and technical guidelines for Federal drug testing programs and establish standards for certification of laboratories engaged in drug testing for Federal agencies under authority of Public Law 100-71, 5 U.S.C. section 7301 note, and Executive Order 12564. Federal drug testing programs test applicants to sensitive positions, individuals involved in accidents, individuals for cause, and random testing of persons in sensitive positions.

*Description of Respondents:* Individuals or households, businesses, or other-for-profit and not-for-profit institutions.

*The burden estimates in the tables below are based on the following number of respondents:* 38,000 donors who apply for employment or are employed in testing designated positions, 100 collectors, 25 urine specimen testing laboratories, 1 IITF, and 100 MROs.

### **Estimate of Annual Reporting Burden**

Section	Purpose	No. of Respondents	Responses/ Respondent	Hours/ Response	Total Hours
9.2(a)(1)	Laboratory or IITF required to submit application for certification	10	1	3	30
9.12(a)(3)	Materials to submit to become an HHS inspector	10	1	2	20
11.3	Laboratory submits qualifications of responsible person (RP) to HHS	10	1	2	20
11.4(c)	Laboratory submits information to HHS on new RP or alternate RP	10	1	2	20
11.22	Specifications for laboratory semiannual statistical report of test results to each Federal agency	10	5	0.5	25

Section	Purpose	No. of Respondents	Responses/ Respondent	Hours/ Response	Total Hours
12.3(a)	IITF <sup>1</sup> submits qualifications of RT to HHS	1	1	1	1
12.4(c)	IITF <sup>1</sup> submits information to HHS on new RT or alternate RT	1	1	1	1
12.19	Specifications for IITF <sup>1</sup> semiannual statistical report of test results to each Federal agency	1	1	1	1
13.9 and 14.7	Specifies that MRO must report all verified primary and split specimen test results to the Federal agency	100	14	0.05 (3 min)	70
13.11	Specifications for MRO semiannual report to the Secretary or designated representative for Federal agency specimen results that were laboratory-positive and MRO-verified negative	100	2	0.5	100

Section	Purpose	No. of Respondents	Responses/ Respondent	Hours/ Response	Total Hours
16.1(b) & 16.5(a)	Specifies content of request for informal review of suspension/proposed revocation of certification	1	1	3	3
16.4	Specifies information appellant provides in first written submission when laboratory suspension/revocation is proposed	1	1	0.5	0.5
16.6	Requires appellant to notify reviewing official of resolution status at end of abeyance period	1	1	0.5	0.5
16.7(a)	Specifies contents of appellant submission for review	1	1	50	50
16.9(a)	Specifies content of appellant request for expedited review of	1	1	3	3

Section	Purpose	No. of Respondents	Responses/ Respondent	Hours/ Response	Total Hours
	suspension or proposed revocation				
16.9(c)	Specifies contents of review file and briefs	1	1	50	50
TOTAL		259			395

<sup>1</sup>Although IITFs are allowed under the UrMG, SAMHSA has not received any IITF application for certification to test federally regulated specimens. IITF numbers are provided in this analysis as placeholders for administrative purposes.

The following reporting requirements are also in the proposed Guidelines, but have not been addressed in the above reporting burden table: collector must report any unusual donor behavior or refusal to participate in the collection process on the Federal CCF (Sections 1.8, 8.9); collector annotates the Federal CCF when a sample is a blind sample (Section 10.3(a)); MRO notifies the Federal agency and HHS when an error occurs on a blind sample (Section 10.4(d)); and Sections 13.6 and 13.7 describe the actions an MRO takes for the medical evaluation of a donor who cannot provide a urine specimen. SAMHSA has not calculated a separate reporting burden for these requirements because they are included in the burden hours estimated for collectors to complete Federal CCFs and for MROs to report results to Federal agencies.

### **Estimate of Annual Disclosure Burden**

Section	Purpose	No. of Respondents	Responses/ Respondent	Hours/ Response	Total Hours
8.3(a), 8.5(f)(2)(i ii), 8.6(b)(2)	Collector must contact Federal agency point of contact	100	1	0.05 (3 min)	5
11.23, 11.24	Information on drug test that laboratory must provide to Federal agency upon request or to donor through MRO	25	10	3	750
12.20, 12.21	Information on drug test that IITF must provide to Federal agency upon request or to donor through MRO	1	1	1	1
13.8(b)	MRO must inform donor of right to request split specimen test when a positive, adulterated, or substituted result is reported	100	14	3	4,200
TOTAL		226			4956

The following disclosure requirements are also included in the proposed Guidelines, but have not been addressed in the above disclosure burden table: the collector must explain the basic collection procedure to the donor and answer any questions (Section 8.3(e) and (g)).

SAMHSA believes having the collector explain the collection procedure to the donor and answer any questions is a standard business practice and not a disclosure burden.

### **Estimate of Annual Recordkeeping Burden**

Section	Purpose	No. of Respondents	Responses/ Respondent	Hours/ Response	Total Hours
8.3, 8.5, 8.8	Collector completes Federal CCF for specimen collected	100	380	0.07 (4 min)	2,660
8.8(d) & (f)	Donor initials specimen labels/seals and signs statement on the Federal CCF	38,000	1	0.08 (5 min)	3,040
11.8(a) & 11.19	Laboratory completes Federal CCF upon receipt of specimen and before reporting result	25	1,520	0.05 (3 min)	1,900
12.8(a) & 12.15	IITF completes Federal CCF upon receipt of specimen and before reporting result	1	1	1	1
13.4(d)(4), 13.9(c), 14.7(c)	MRO completes Federal CCF before reporting the primary or split specimen result	100	380	0.05 (3 min)	1,900

Section	Purpose	No. of Respondents	Responses/ Respondent	Hours/ Response	Total Hours
14.1(b)	MRO documents donor's request to have split specimen tested	100	2	0.05 (3 min)	10
TOTAL		38,326			9,511

The proposed Guidelines contain several recordkeeping requirements that SAMHSA considers not to be an additional recordkeeping burden. In subpart D, a trainer is required to document the training of an individual to be a collector (Section 4.3(a)(3)) and the documentation must be maintained in the collector's training file (Section 4.3(c)). SAMHSA believes this training documentation is common practice and is not considered an additional burden. In subpart F, if a collector uses an incorrect form to collect a Federal agency specimen, the collector is required to provide a statement (Section 6.2(b)) explaining why an incorrect form was used to document collecting the specimen. SAMHSA believes this is an extremely infrequent occurrence and does not create a significant additional recordkeeping burden. Subpart H (Sections 8.4(c), 8.5(d)(2), 8.5(e)(1) and (2)) requires collectors to enter any information on the Federal CCF of any unusual findings during the urine specimen collection procedure. These recordkeeping requirements are an integral part of the collection procedure and are essential to documenting the chain of custody for the specimens collected. The burden for these entries is included in the recordkeeping burden estimated to complete the Federal CCF and is, therefore, not considered an additional recordkeeping burden. Subpart K describes a number of recordkeeping requirements for laboratories associated with their testing procedures, maintaining chain of custody, and keeping records (i.e., Sections 11.1(a) and (d); 11.2(b), (c), and (d); 11.6(b); 11.7(c); 11.8; 11.11(a); 11.14(a); 11.17; 11.21(a), (b), and (c); 11.22; 11.23(a); and

11.24). These recordkeeping requirements are necessary for any laboratory to conduct forensic drug testing and to ensure the scientific supportability of the test results. Therefore, they are considered to be standard business practice and are not considered a burden for this analysis.

Thus, the total annual response burden associated with the testing of urine specimens by the laboratories and IITFs is estimated to be 14,862 hours (that is, the sum of the total hours from the above tables). This is in addition to the 1,788,809 hours currently approved by OMB under control number 0930-0158 for urine testing under the current Guidelines.

As required by section 3507(d) of the PRA, the Secretary has submitted a copy of these proposed Guidelines to OMB for its review. Comments on the information collection requirements are specifically solicited in order to: (1) Evaluate whether the proposed collection of information is necessary for the proper performance of HHS's functions, including whether the information will have practical utility; (2) evaluate the accuracy of HHS's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) enhance the quality, utility, and clarity of the information to be collected; and (4) minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

OMB is required to make a decision concerning the collection of information contained in these proposed Guidelines between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication. This does not affect the deadline for the public to comment to HHS on the proposed Guidelines.

Organizations and individuals desiring to submit comments on the information collection requirements should direct them to the Office of Information and Regulatory Affairs, OMB, New Executive Office Building, 725 17<sup>th</sup> Street, NW, Washington, DC 20502, Attn: Desk Officer for

SAMHSA. Because of delays in receipt of mail, comments may also be sent to 202-395-6974 (fax).

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## **Summary**

These proposed revisions are intended to simplify changes to the authorized drug testing panel for Federal workplace drug testing programs, facilitate the identification of substituted specimens using biomarker testing, improve detection of illicit codeine and/or morphine use, and provide the Department with information on Federal agency drug test specimens that were reported as positive for a drug or drug metabolite by a laboratory and verified negative by the Medical Review Officer (MRO). The Department believes that the proposed revisions to the Mandatory Guidelines save costs and improve the effectiveness of Federal workplace drug testing programs.

**Dated:** March 22, 2022.

**Miriam E. Delphin-Rittmon,**

*Assistant Secretary for Mental Health and Substance Use,*

*Substance Abuse and Mental Health Services Administration.*

Approved: March 22, 2022.

**Xavier Becerra,**

*Secretary,*

*Department of Health and Human Services.*

## **MANDATORY GUIDELINES FOR FEDERAL WORKPLACE DRUG TESTING PROGRAMS USING URINE SPECIMENS**

### **Subpart A - Applicability**

- 1.1 To whom do these Guidelines apply?
- 1.2 Who is responsible for developing and implementing these Guidelines?
- 1.3 How does a federal agency request a change from these Guidelines?
- 1.4 How are these Guidelines revised?
- 1.5 What do the terms used in these Guidelines mean?
- 1.6 What is an agency required to do to protect employee records?
- 1.7 What is a refusal to take a federally regulated drug test?
- 1.8 What are the potential consequences for refusing to take a federally regulated drug test?

### **Subpart B -Urine Specimens**

- 2.1 What type of specimen may be collected?
- 2.2 Under what circumstances may a urine specimen be collected?

- 2.3 How is each urine specimen collected?
- 2.4 What volume of urine is collected?
- 2.5 How does the collector split the urine specimen?
- 2.6 When may an entity or individual release a urine specimen?

### **Subpart C – Urine Specimen Tests**

- 3.1 Which tests are conducted on a urine specimen?
- 3.2 May a specimen be tested for drugs other than those in the drug testing panel?
- 3.3 May any of the specimens be used for other purposes?
- 3.4 What are the drug and biomarker test analytes and cutoffs for urine?
- 3.5 May an HHS-certified laboratory perform additional drug and/or specimen validity tests on a specimen at the request of the Medical Review Officer (MRO)?
- 3.6 What criteria are used to report a urine specimen as adulterated?
- 3.7 What criteria are used to report a urine specimen as substituted?
- 3.8 What criteria are used to report a urine specimen as dilute?
- 3.9 What criteria are used to report an invalid result for a urine specimen?

### **Subpart D - Collectors**

- 4.1 Who may collect a specimen?
- 4.2 Who may not collect a specimen?
- 4.3 What are the requirements to be a collector?
- 4.4 What are the requirements to be an observer for a direct observed collection?
- 4.5 What are the requirements to be a trainer for collectors?
- 4.6 What must a federal agency do before a collector is permitted to collect a specimen?

### **Subpart E - Collection Sites**

- 5.1 Where can a collection for a drug test take place?
- 5.2 What are the requirements for a collection site?
- 5.3 Where must collection site records be stored?
- 5.4 How long must collection site records be stored?
- 5.5 How does the collector ensure the security and integrity of a specimen at the collection site?
- 5.6 What are the privacy requirements when collecting a urine specimen?

### **Subpart F - Federal Drug Testing Custody and Control Form**

- 6.1 What federal form is used to document custody and control?
- 6.2 What happens if the correct OMB-approved Federal CCF is not available or is not used?

### **Subpart G – Urine Specimen Collection Containers and Bottles**

- 7.1 What is used to collect a urine specimen?
- 7.2 What are the requirements for a urine collection container and specimen bottles?
- 7.3 What are the minimum performance requirements for a urine collection container and specimen bottles?

### **Subpart H - Urine Specimen Collection Procedure**

- 8.1 What privacy must the donor be given when providing a urine specimen?
- 8.2 What must the collector ensure at the collection site before starting a urine specimen collection?
- 8.3 What are the preliminary steps in the urine specimen collection procedure?
- 8.4 What steps does the collector take in the collection procedure before the donor provides a urine specimen?
- 8.5 What steps does the collector take during and after the urine specimen collection

procedure?

- 8.6 What procedure is used when the donor states that they are unable to provide a urine specimen?
- 8.7 If the donor is unable to provide a urine specimen, may another specimen type be collected for testing?
- 8.8 How does the collector prepare the urine specimens?
- 8.9 When is a direct observed collection conducted?
- 8.10 How is a direct observed collection conducted?
- 8.11 When is a monitored collection conducted?
- 8.12 How is a monitored collection conducted?
- 8.13 How does the collector report a donor's refusal to test?
- 8.14 What are a federal agency's responsibilities for a collection site?

#### **Subpart I - HHS Certification of Laboratories and IITFs**

- 9.1 Who has the authority to certify laboratories and IITFs to test urine specimens for federal agencies?
- 9.2 What is the process for a laboratory or IITF to become HHS-certified?
- 9.3 What is the process for a laboratory or IITF to maintain HHS certification?
- 9.4 What is the process when a laboratory or IITF does not maintain its HHS certification?
- 9.5 What are the qualitative and quantitative specifications of performance testing (PT) samples?
- 9.6 What are the PT requirements for an applicant laboratory?
- 9.7 What are the PT requirements for an HHS-certified urine laboratory?
- 9.8 What are the PT requirements for an applicant IITF?
- 9.9 What are the PT requirements for an HHS-certified IITF?
- 9.10 What are the inspection requirements for an applicant laboratory or IITF?

- 9.11 What are the maintenance inspection requirements for an HHS-certified laboratory or IITF?
- 9.12 Who can inspect an HHS-certified laboratory or IITF and when may the inspection be conducted?
- 9.13 What happens if an applicant laboratory or IITF does not satisfy the minimum requirements for either the PT program or the inspection program?
- 9.14 What happens if an HHS-certified laboratory or IITF does not satisfy the minimum requirements for either the PT program or the inspection program?
- 9.15 What factors are considered in determining whether revocation of a laboratory's or IITF's HHS certification is necessary?
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### **Subpart A - Applicability**

#### Section 1.1 To whom do these Guidelines apply?

(a) These Guidelines apply to:

(1) Executive Agencies as defined in 5 U.S.C. 105;

(2) The Uniformed Services, as defined in 5 U.S.C. 2101(3), but excluding the Armed Forces as defined in 5 U.S.C. 2101(2);

(3) Any other employing unit or authority of the federal government except the United States Postal Service, the Postal Rate Commission, and employing units or authorities in the Judicial and Legislative Branches; and

(4) The Intelligence Community, as defined by Executive Order 12333, is subject to these Guidelines only to the extent agreed to by the head of the affected agency;

(5) Laboratories and instrumented initial test facilities (IITFs) that provide drug testing services to the federal agencies;

(6) Collectors who provide specimen collection services to the federal agencies; and

(7) Medical Review Officers (MROs) who provide drug testing review and interpretation of results services to the federal agencies.

(b) These Guidelines do not apply to drug testing under authority other than Executive Order 12564, including testing of persons in the criminal justice system, such as arrestees, detainees, probationers, incarcerated persons, or parolees.

#### Section 1.2 Who is responsible for developing and implementing these Guidelines?

(a) Executive Order 12564 and Public Law 100-71 require the Department of Health and Human Services (HHS) to establish scientific and technical guidelines for federal workplace drug testing programs.

(b) The Secretary has the responsibility to implement these Guidelines.

#### Section 1.3 How does a federal agency request a change from these Guidelines?

(a) Each federal agency must ensure that its workplace drug testing program complies with the provisions of these Guidelines unless a waiver has been obtained from the Secretary.

(b) To obtain a waiver, a federal agency must submit a written request to the Secretary

that describes the specific change for which a waiver is sought and a detailed justification for the change.

#### Section 1.4 How are these Guidelines revised?

(a) To ensure the full reliability and accuracy of specimen tests, the accurate reporting of test results, and the integrity and efficacy of federal drug testing programs, the Secretary may make changes to these Guidelines to reflect improvements in the available science and technology.

(b) Revisions to these Guidelines will be published in final as a notice in the **Federal Register**.

#### Section 1.5 What do the terms used in these Guidelines mean?

The following definitions are adopted:

Accessioner. The individual who signs the Federal Drug Testing Custody and Control Form at the time of specimen receipt at the HHS-certified laboratory or (for urine) the HHS-certified IITF.

Adulterated Specimen. A specimen that has been altered, as evidenced by test results showing either a substance that is not a normal constituent for that type of specimen or showing an abnormal concentration of a normal constituent (e.g., nitrite in urine).

Aliquot. A portion of a specimen used for testing.

Alternate Responsible Person. The person who assumes professional, organizational, educational, and administrative responsibility for the day-to-day management of the HHS-certified laboratory when the responsible person is unable to fulfill these obligations.

Alternate Responsible Technician. The person who assumes professional, organizational, educational, and administrative responsibility for the day-to-day management of the HHS-certified IITF when the responsible technician is unable to fulfill these obligations.

Alternate Technology Initial Drug Test. An initial drug test using technology other than immunoassay to differentiate negative specimens from those requiring further testing.

Batch. A number of specimens or aliquots handled concurrently as a group.

Biomarker. An endogenous substance used to validate a biological specimen.

Biomarker Testing Panel. The panel published in the **Federal Register** that includes the biomarkers authorized for testing, with analytes and cutoffs for initial and confirmatory biomarker tests, as described under Section 3.4.

Blind Sample. A sample submitted to an HHS-certified test facility for quality assurance purposes, with a fictitious identifier, so that the test facility cannot distinguish it from a donor specimen.

Calibrator. A sample of known content and analyte concentration prepared in the appropriate matrix used to define expected outcomes of a testing procedure. The test result of the calibrator is verified to be within established limits prior to use.

Cancelled Test. The result reported by the MRO to the federal agency when a specimen has been reported to the MRO as an invalid result (and the donor has no legitimate explanation) or rejected for testing, when a split specimen fails to reconfirm, or when the MRO determines that a fatal flaw or unrecovered correctable flaw exists in the forensic records (as described in Sections 15.1 and 15.2).

Carryover. The effect that occurs when a sample result (e.g., drug concentration) is affected by a preceding sample during the preparation or analysis of a sample.

Certifying Scientist (CS). The individual responsible for verifying the chain of custody and scientific reliability of a test result reported by an HHS-certified laboratory.

Certifying Technician (CT). The individual responsible for verifying the chain of custody and scientific reliability of negative, rejected for testing, and (for urine) negative/dilute results reported by an HHS-certified laboratory or (for urine) an HHS-certified IITF.

Chain of Custody (COC) Procedures. Procedures that document the integrity of each

specimen or aliquot from the point of collection to final disposition.

Chain of Custody Documents. Forms used to document the control and security of the specimen and all aliquots. The document may account for an individual specimen, aliquot, or batch of specimens/aliquots and must include the name and signature of each individual who handled the specimen(s) or aliquot(s) and the date and purpose of the handling.

Collection Container. A receptacle used to collect a donor's drug test specimen.

Collection Site. The location where specimens are collected.

Collector. A person trained to instruct and assist a donor in providing a specimen.

Confirmatory Drug Test. A second analytical procedure performed on a separate aliquot of a specimen to identify and quantify a specific drug or drug metabolite.

Confirmatory Specimen Validity Test. A second test performed on a separate aliquot of a specimen to further support a specimen validity test result.

Control. A sample used to evaluate whether an analytical procedure or test is operating within predefined tolerance limits.

Cutoff. The analytical value (e.g., drug, drug metabolite, or biomarker concentration) used as the decision point to determine a result (e.g., negative, positive, adulterated, invalid, or substituted) or the need for further testing.

Dilute Specimen. A urine specimen with creatinine and specific gravity values that are lower than expected but are still within the physiologically producible ranges of human urine.

Donor. The individual from whom a specimen is collected.

Drug Testing Panel. The panel published in the **Federal Register** that includes the drugs authorized for testing, with analytes and cutoffs for initial and confirmatory drug tests, as described under Section 3.4.

External Service Provider. An independent entity that performs services related to federal workplace drug testing on behalf of a federal agency, a collector/collection site, an HHS-certified laboratory, a Medical Review Officer (MRO), or (for urine) an HHS-certified

Instrumented Initial Test Facility (IITF).

Failed to Reconfirm. The result reported for a split (B) specimen when a second HHS-certified laboratory is unable to corroborate the result reported for the primary (A) specimen.

Federal Drug Testing Custody and Control Form (Federal CCF). The Office of Management and Budget (OMB) approved form that is used to document the collection and chain of custody of a specimen from the time the specimen is collected until it is received by the test facility (i.e., HHS-certified laboratory or, for urine, HHS-certified IITF). It may be a paper (hardcopy), electronic, or combination electronic and paper format (hybrid). The form may also be used to report the test result to the Medical Review Officer.

Gender Identity. Gender identity means an individual's internal sense of being male or female, which may be different from an individual's sex assigned at birth.

HHS. The Department of Health and Human Services.

Initial Drug Test. An analysis used to differentiate negative specimens from those requiring further testing.

Initial Specimen Validity Test. The first analysis used to determine if a specimen is adulterated, invalid, substituted, or (for urine) dilute.

Instrumented Initial Test Facility (IITF). A permanent location where (for urine) initial testing, reporting of results, and recordkeeping are performed under the supervision of a responsible technician.

Invalid Result. The result reported by an HHS-certified laboratory in accordance with the criteria established in Section 3.9 when a positive, negative, adulterated, or substituted result cannot be established for a specific drug or specimen validity test.

Laboratory. A permanent location where initial and confirmatory drug testing, reporting of results, and recordkeeping are performed under the supervision of a responsible person.

Limit of Detection. The lowest concentration at which the analyte (e.g., drug or drug metabolite) can be identified.

Limit of Quantification (LOQ). For quantitative assays, the lowest concentration at which the identity and concentration of the analyte (e.g., drug or drug metabolite) can be accurately established.

Lot. A number of units of an item (e.g., reagents, quality control material) manufactured from the same starting materials within a specified period of time for which the manufacturer ensures that the items have essentially the same performance characteristics and expiration date.

Medical Review Officer (MRO). A licensed physician who reviews, verifies, and reports a specimen test result to the federal agency.

Negative Result. The result reported by an HHS-certified laboratory or (for urine) an HHS-certified IITF to an MRO when a specimen contains no drug and/or drug metabolite; or the concentration of the drug or drug metabolite is less than the cutoff for that drug or drug class.

Oral Fluid Specimen. An oral fluid specimen is collected from the donor's oral cavity and is a combination of physiological fluids produced primarily by the salivary glands.

Oxidizing Adulterant. A substance that acts alone or in combination with other substances to oxidize drug or drug metabolites to prevent the detection of the drugs or drug metabolites, or affects the reagents in either the initial or confirmatory drug test.

Performance Testing (PT) Sample. A program-generated sample sent to a laboratory or (for urine) to an IITF to evaluate performance.

Positive Result. The result reported by an HHS-certified laboratory when a specimen contains a drug or drug metabolite equal to or greater than the confirmatory test cutoff.

Reconfirmed. The result reported for a split (B) specimen when the second HHS-certified laboratory corroborates the original result reported for the primary (A) specimen.

Rejected for Testing. The result reported by an HHS-certified laboratory or (for urine) HHS-certified IITF when no tests are performed on a specimen because of a fatal flaw or an unrecovered correctable error (see Sections 15.1 and 15.2).

Responsible Person (RP). The person who assumes professional, organizational,

educational, and administrative responsibility for the day-to-day management of an HHS-certified laboratory.

Responsible Technician (RT). The person who assumes professional, organizational, educational, and administrative responsibility for the day-to-day management of an HHS-certified IITF.

Sample. A performance testing sample, calibrator or control used during testing, or a representative portion of a donor's specimen.

Secretary. The Secretary of the U.S. Department of Health and Human Services.

Specimen. Fluid or material collected from a donor at the collection site for the purpose of a drug test.

Split Specimen Collection (for Urine). A collection in which the specimen collected is divided into a primary (A) specimen and a split (B) specimen, which are independently sealed in the presence of the donor.

Standard. Reference material of known purity or a solution containing a reference material at a known concentration.

Substituted Specimen. A specimen that has been submitted in place of the donor's specimen, as evidenced by the absence of a biomarker or a biomarker concentration inconsistent with that established for a human specimen, as indicated in the biomarker testing panel, or (for urine) creatinine and specific gravity values that are outside the physiologically producible ranges of human urine, in accordance with the criteria to report a specimen as substituted in UrMG Section 3.7.

#### Section 1.6 What is an agency required to do to protect employee records?

Consistent with 5 U.S.C. 552a and 48 CFR 24.101-24.104, all agency contracts with laboratories, IITFs, collectors, and MROs must require that they comply with the Privacy Act, 5 U.S.C. 552a. In addition, the contracts must require compliance with employee access and

confidentiality provisions of Section 503 of Public Law 100-71. Each federal agency must establish a Privacy Act System of Records or modify an existing system or use any applicable Government-wide system of records to cover the records of employee drug test results. All contracts and the Privacy Act System of Records must specifically require that employee records be maintained and used with the highest regard for employee privacy.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule (Rule), 45 CFR parts 160 and 164, subparts A and E, may be applicable to certain health care providers with whom a federal agency may contract. If a health care provider is a HIPAA covered entity, the provider must protect the individually identifiable health information it maintains in accordance with the requirements of the Rule, which includes not using or disclosing the information except as permitted by the Rule and ensuring there are reasonable safeguards in place to protect the privacy of the information. For more information regarding the HIPAA Privacy Rule, please visit <https://www.hhs.gov/hipaa/index.html>.

#### Section 1.7 What is a refusal to take a federally regulated drug test?

(a) As a donor for a federally regulated drug test, you have refused to take a federally regulated drug test if you:

(1) Fail to appear for any test within a reasonable time, as determined by the federal agency, consistent with applicable agency regulations, after being directed to do so by the federal agency;

(2) Fail to remain at the collection site until the collection process is complete;

(3) Fail to provide a specimen (e.g., urine or another authorized specimen type) for any drug test required by these Guidelines or federal agency regulations;

(4) In the case of a direct observed or monitored collection, fail to permit the observation or monitoring of your provision of a specimen when required as described in Sections 8.9 and 8.10;

(5) Fail to provide a sufficient amount of urine when directed, and it has been determined, through a required medical evaluation, that there was no legitimate medical explanation for the failure as determined by the process described in Section 13.6;

(6) Fail or decline to participate in an alternate specimen collection (e.g., oral fluid) as directed by the federal agency or collector (i.e., as described in Section 8.6);

(7) Fail to undergo a medical examination or evaluation, as directed by the MRO as part of the verification process (i.e., Section 13.6) or as directed by the federal agency. In the case of a federal agency applicant/pre-employment drug test, the donor is deemed to have refused to test on this basis only if the federal agency applicant/pre-employment test is conducted following a contingent offer of employment. If there was no contingent offer of employment, the MRO will cancel the test;

(8) Fail to cooperate with any part of the testing process (e.g., refuse to empty pockets when directed by the collector, disrupt the collection process, fail to wash hands after being directed to do so by the collector);

(9) For an observed collection, fail to follow the observer's instructions related to the collection process;

(10) Bring materials to the collection site for the purpose of adulterating, substituting, or diluting the specimen;

(11) Attempt to adulterate, substitute, or dilute the specimen;

(12) Possess or wear a prosthetic or other device that could be used to interfere with the collection process; or

(13) Admit to the collector or MRO that you have adulterated or substituted the specimen.

Section 1.8    What are the potential consequences for refusing to take a federally regulated drug test?

(a) A refusal to take a test may result in the initiation of disciplinary or adverse action for a federal employee, up to and including removal from federal employment. An applicant's refusal to take a pre-employment test may result in non-selection for federal employment.

(b) When a donor has refused to participate in a part of the collection process, including failing to appear in a reasonable time for any test, the collector must terminate the collection process and take action as described in Section 8.13. Required action includes immediately notifying the federal agency's designated representative by any means (e.g., telephone or secure facsimile [fax] machine) that ensures that the refusal notification is immediately received and, if a Federal CCF has been initiated, documenting the refusal on the Federal CCF, signing and dating the Federal CCF, and sending all copies of the Federal CCF to the federal agency's designated representative.

(c) When documenting a refusal to test during the verification process as described in Sections 13.4, 13.5, and 13.6, the MRO must complete the MRO copy of the Federal CCF to include:

- (1) Checking the refusal to test box;
- (2) Providing a reason for the refusal in the remarks line; and
- (3) Signing and dating the MRO copy of the Federal CCF.

## **Subpart B – Urine Specimens**

### Section 2.1 What type of specimen may be collected?

A federal agency may collect urine and/or an alternate specimen type for its workplace drug testing program. Only specimen types authorized by Mandatory Guidelines for Federal Workplace Drug Testing Programs may be collected. An agency using urine must follow these Guidelines.

## Section 2.2 Under what circumstances may a urine specimen be collected?

A federal agency may collect a urine specimen for the following reasons:

- (a) Federal agency applicant/Pre-employment test;
- (b) Random test;
- (c) Reasonable suspicion/cause test;
- (d) Post accident test;
- (e) Return to duty test; or
- (f) Follow-up test.

## Section 2.3 How is each urine specimen collected?

Each urine specimen is collected as a split specimen as described in Section 2.5.

## Section 2.4 What volume of urine is collected?

A donor is expected to provide at least 45 mL of urine for a specimen.

## Section 2.5 How does the collector split the urine specimen?

The collector pours at least 30 mL into a specimen bottle that is designated as A (primary) and then pours at least 15 mL into a specimen bottle that is designated as B (split).

## Section 2.6 When may an entity or individual release a urine specimen?

Entities and individuals subject to these Guidelines under Section 1.1 may not release specimens collected pursuant to Executive Order 12564, Public Law 100-71, and these Guidelines to donors or their designees. Specimens also may not be released to any other entity or individual unless expressly authorized by these Guidelines or by applicable federal law. This section does not prohibit a donor's request to have a split (B) specimen tested in accordance with Section 13.8.

## **Subpart C – Urine Specimen Tests**

### Section 3.1 Which tests are conducted on a urine specimen?

A federal agency:

(a) Must ensure that each specimen is tested for marijuana and cocaine metabolites as provided in the drug testing panel described under Section 3.4;

(b) Is authorized to test each specimen for other Schedule I or II drugs as provided in the drug testing panel;

(c) Must ensure that the following specimen validity tests are conducted on each urine specimen:

(1) Determine the creatinine concentration on every specimen;

(2) Determine the specific gravity on every specimen for which the creatinine concentration is less than 20 mg/dL;

(3) Determine the pH on every specimen; and

(4) Perform one or more specimen validity tests for oxidizing adulterants on every specimen.

(d) Is authorized to test each specimen for one or more biomarkers as provided in the biomarker testing panel; and

(e) If a specimen exhibits abnormal characteristics (e.g., unusual odor or color, semi-solid characteristics), causes reactions or responses characteristic of an adulterant during initial or confirmatory drug tests (e.g., non-recovery of internal standard, unusual response), or contains an unidentified substance that interferes with the confirmatory analysis, then additional testing may be performed.

### Section 3.2 May a specimen be tested for drugs other than those in the drug testing panel?

(a) On a case-by-case basis, a specimen may be tested for additional drugs, if a federal agency is conducting the collection for reasonable suspicion or post accident testing. A specimen collected from a federal agency employee may be tested by the federal agency for any drugs listed in Schedule I or II of the Controlled Substances Act. The federal agency must request the HHS-certified laboratory to test for the additional drug, include a justification to test a specific specimen for the drug, and ensure that the HHS-certified laboratory has the capability to test for the drug and has established properly validated initial and confirmatory analytical methods. If an initial test procedure is not available upon request for a suspected Schedule I or Schedule II drug, the federal agency can request an HHS-certified laboratory to test for the drug by analyzing two separate aliquots of the specimen in two separate testing batches using the confirmatory analytical method. Additionally, the split (B) specimen will be available for testing if the donor requests a retest at another HHS-certified laboratory.

(b) A federal agency covered by these Guidelines must petition the Secretary in writing for approval to routinely test for any drug class not listed in the drug testing panel described under Section 3.4. Such approval must be limited to the use of the appropriate science and technology and must not otherwise limit agency discretion to test for any drug tested under paragraph (a) of this section.

### Section 3.3 May any of the specimens be used for other purposes?

(a) Specimens collected pursuant to Executive Order 12564, Public Law 100-71, and these Guidelines must only be tested for drugs and to determine their validity in accordance with Subpart C of these Guidelines. Use of specimens by donors, their designees, or any other entity, for other purposes (e.g., deoxyribonucleic acid, DNA, testing) is prohibited unless authorized in accordance with applicable federal law.

(b) These Guidelines are not intended to prohibit federal agencies specifically authorized by law to test a specimen for additional classes of drugs in its workplace drug testing program.

### Section 3.4 What are the drug and biomarker test analytes and cutoffs for urine?

The Secretary will publish the drug and biomarker test analytes and cutoffs (i.e., the “drug testing panel” and “biomarker testing panel”) for initial and confirmatory drug and biomarker tests in the **Federal Register** each year. The drug and biomarker testing panels will also be available on the Internet at <http://www.samhsa.gov/workplace/drug-testing>.

This drug testing panel will remain in effect until the effective date of a new drug testing panel published in the **Federal Register**:

Initial Test Analyte	Initial Test Cutoff <sup>1</sup>	Confirmatory Test Analyte	Confirmatory Test Cutoff Concentration
Marijuana metabolite (THCA) <sup>2</sup>	50 ng/mL <sup>3</sup>	THCA	15 ng/mL
Cocaine metabolite (Benzoylecgonine)	150 ng/mL <sup>3</sup>	Benzoylecgonine	100 ng/mL
Codeine/ Morphine	2000 ng/mL	Codeine Morphine	2000 ng/mL 4000 ng/mL
Hydrocodone/ Hydromorphone	300 ng/mL	Hydrocodone Hydromorphone	100 ng/mL 100 ng/mL
Oxycodone/ Oxymorphone	100 ng/mL	Oxycodone Oxymorphone	100 ng/mL 100 ng/mL
6-Acetylmorphine	10 ng/mL	6-Acetylmorphine	10 ng/mL
Phencyclidine	25 ng/mL	Phencyclidine	25 ng/mL

Amphetamine/ Methamphetamine	500 ng/mL	Amphetamine Methamphetamine	250 ng/mL 250 ng/mL
MDMA <sup>4</sup> /MDA <sup>5</sup>	500 ng/mL	MDMA MDA	250 ng/mL 250 ng/mL
<p><sup>1</sup>For grouped analytes (i.e., two or more analytes that are in the same drug class and have the same initial test cutoff):</p> <p><b>Immunoassay:</b> The test must be calibrated with one analyte from the group identified as the target analyte. The cross-reactivity of the immunoassay to the other analyte(s) within the group must be 80 percent or greater; if not, separate immunoassays must be used for the analytes within the group.</p> <p><b>Alternate technology:</b> Either one analyte or all analytes from the group must be used for calibration, depending on the technology. At least one analyte within the group must have a concentration equal to or greater than the initial test cutoff or, alternatively, the sum of the analytes present (i.e., equal to or greater than the laboratory's validated limit of quantification) must be equal to or greater than the initial test cutoff.</p>			
<p><sup>2</sup>An immunoassay must be calibrated with the target analyte, Δ-9-tetrahydrocannabinol-9-carboxylic acid (THCA).</p>			
<p><sup>3</sup><b>Alternate technology (THCA and benzoylecgonine):</b> The confirmatory test cutoff must be used for an alternate technology initial test that is specific for the target analyte (i.e., 15 ng/mL for THCA, 100 ng/mL for benzoylecgonine).</p>			
<p><sup>4</sup>Methylenedioxymethamphetamine (MDMA)</p>			
<p><sup>5</sup>Methylenedioxyamphetamine (MDA)</p>			

(a) The drug testing panel will include drugs authorized for testing in federal workplace drug testing programs, with the required test analytes and cutoffs;

(b) The biomarker testing panel will include biomarkers authorized for testing in federal workplace drug testing programs, with the required test analytes and cutoffs; and

(c) HHS-certified IITFs, HHS-certified laboratories, and Medical Review Officers must use the nomenclature (i.e., analyte names and abbreviations) published in the **Federal Register** with the drug and biomarker testing panels to report federal workplace drug test results.

Section 3.5 May an HHS-certified laboratory perform additional drug and/or specimen validity tests on a specimen at the request of the Medical Review Officer (MRO)?

An HHS-certified laboratory is authorized to perform additional drug and/or specimen validity tests on a case-by-case basis as necessary to provide information that the MRO would use to report a verified drug test result (e.g., tetrahydrocannabivarin, specimen validity tests). An HHS-certified laboratory is not authorized to routinely perform additional drug and/or specimen validity tests at the request of an MRO without prior authorization from the Secretary or designated HHS representative, with the exception of the determination of D,L stereoisomers of amphetamine and methamphetamine. All tests must meet appropriate validation and quality control requirements in accordance with these Guidelines.

Section 3.6 What criteria are used to report a urine specimen as adulterated?

An HHS-certified laboratory reports a primary (A) specimen as adulterated when:

(a) The pH is less than 4 or equal to or greater than 11 using either a pH meter or a colorimetric pH test for the initial test on the first aliquot and a pH meter for the confirmatory test on the second aliquot;

(b) The nitrite concentration is equal to or greater than 500 mcg/mL using either a nitrite colorimetric test or a general oxidant colorimetric test for the initial test on the first aliquot and a different confirmatory test (e.g., multi-wavelength spectrophotometry, ion chromatography, capillary electrophoresis) on the second aliquot;

(c) The presence of chromium (VI) is verified using either a general oxidant colorimetric test (with an equal to or greater than 50 mcg/mL chromium (VI)-equivalent cutoff) or a chromium (VI) colorimetric test (chromium (VI) concentration equal to or greater than 50 mcg/mL) for the initial test on the first aliquot and a different confirmatory test (e.g., multi-wavelength spectrophotometry, ion chromatography, atomic absorption spectrophotometry, capillary electrophoresis, inductively coupled plasma-mass spectrometry) with the chromium (VI) concentration equal to or greater than the LOQ of the confirmatory test on the second aliquot;

(d) The presence of a halogen (e.g., chlorine from bleach, iodine, fluoride) is verified using either a general oxidant colorimetric test (with an equal to or great than 200 mcg/mL nitrite-equivalent cutoff or an equal to or great than 50 mcg/mL chromium (VI)-equivalent cutoff) or halogen colorimetric test (halogen concentration equal to or greater than the LOQ) for the initial test on the first aliquot and a different confirmatory test (e.g., multi-wavelength spectrophotometry, ion chromatography, inductively coupled plasma-mass spectrometry) with a specific halogen concentration equal to or greater than the LOQ of the confirmatory test on the second aliquot;

(e) The presence of glutaraldehyde is verified using either an aldehyde test (aldehyde present) or the characteristic immunoassay response on one or more drug immunoassay tests for the initial test on the first aliquot and a different confirmatory test (e.g., GC/MS) for the confirmatory test with the glutaraldehyde concentration equal to or greater than the LOQ of the analysis on the second aliquot;

(f) The presence of pyridine (pyridinium chlorochromate) is verified using either a general oxidant colorimetric test (with an equal to or greater than 200 mcg/mL nitrite-equivalent cutoff or an equal to or greater than 50 mcg/mL chromium (VI)-equivalent cutoff) or a chromium (VI) colorimetric test (chromium (VI) concentration equal to or greater than 50 mcg/mL) for the initial test on the first aliquot and a different confirmatory test (e.g., GC/MS)

for the confirmatory test with the pyridine concentration equal to or greater than the LOQ of the analysis on the second aliquot;

(g) The presence of a surfactant is verified by using a surfactant colorimetric test with an equal to or greater than 100 mcg/mL dodecylbenzene sulfonate-equivalent cutoff for the initial test on the first aliquot and a different confirmatory test (e.g., multi-wavelength spectrophotometry) with an equal to or greater than 100 mcg/mL dodecylbenzene sulfonate-equivalent cutoff on the second aliquot; or

(h) The presence of any other adulterant not specified in paragraphs (b) through (g) of this section is verified using an initial test on the first aliquot and a different confirmatory test on the second aliquot.

### Section 3.7 What criteria are used to report a urine specimen as substituted?

An HHS-certified laboratory reports a primary (A) specimen as substituted when:

(a) The creatinine concentration is less than 2 mg/dL on both the initial and confirmatory creatinine tests on two separate aliquots (i.e., the same colorimetric test may be used to test both aliquots) and the specific gravity is less than or equal to 1.0010 or equal to or greater than 1.0200 on both the initial and confirmatory specific gravity tests on two separate aliquots (i.e., a refractometer is used to test both aliquots), or

(b) A biomarker is not detected or is present at a concentration inconsistent with that established for human urine for both the initial (first) test and the confirmatory (second) test on two separate aliquots (i.e., using the test analytes and cutoffs in the biomarker testing panel).

### Section 3.8 What criteria are used to report a urine specimen as dilute?

A dilute result may be reported only in conjunction with the positive or negative drug test results for a specimen.

(a) An HHS-certified laboratory or an HHS-certified IITF reports a primary (A) specimen

as dilute when the creatinine concentration is greater than 5 mg/dL but less than 20 mg/dL and the specific gravity is equal to or greater than 1.002 but less than 1.003 on a single aliquot.

(b) In addition, an HHS-certified laboratory reports a primary (A) specimen as dilute when the creatinine concentration is equal to or greater than 2 mg/dL but less than 20 mg/dL and the specific gravity is greater than 1.0010 but less than 1.0030.

### Section 3.9 What criteria are used to report an invalid result for a urine specimen?

An HHS-certified laboratory reports a primary (A) specimen as an invalid result when:

(a) Inconsistent creatinine concentration and specific gravity results are obtained (i.e., the creatinine concentration is less than 2 mg/dL on both the initial and confirmatory creatinine tests and the specific gravity is greater than 1.0010 but less than 1.0200 on the initial and/or confirmatory specific gravity test, the specific gravity is less than or equal to 1.0010 on both the initial and confirmatory specific gravity tests and the creatinine concentration is equal to or greater than 2 mg/dL on either or both the initial or confirmatory creatinine tests);

(b) The pH is equal to or greater than 4 and less than 4.5 or equal to or greater than 9 and less than 11 using either a colorimetric pH test or pH meter for the initial test and a pH meter for the confirmatory test on two separate aliquots;

(c) The nitrite concentration is equal to or greater than 200 mcg/mL using a nitrite colorimetric test or equal to or greater than the equivalent of 200 mcg/mL nitrite using a general oxidant colorimetric test for both the initial (first) test and the second test or using either initial test and the nitrite concentration is equal to or greater than 200 mcg/mL but less than 500 mcg/mL for a different confirmatory test (e.g., multi-wavelength spectrophotometry, ion chromatography, capillary electrophoresis) on two separate aliquots;

(d) The possible presence of chromium (VI) is determined using the same chromium (VI) colorimetric test with a cutoff equal to or greater than 50 mcg/mL chromium (VI) for both the initial (first) test and the second test on two separate aliquots;

(e) The possible presence of a halogen (e.g., chlorine from bleach, iodine, fluoride) is determined using the same halogen colorimetric test with a cutoff equal to or greater than the LOQ for both the initial (first) test and the second test on two separate aliquots or relying on the odor of the specimen as the initial test;

(f) The possible presence of glutaraldehyde is determined by using the same aldehyde test (aldehyde present) or characteristic immunoassay response on one or more drug immunoassay tests for both the initial (first) test and the second test on two separate aliquots;

(g) The possible presence of an oxidizing adulterant is determined by using the same general oxidant colorimetric test (with an equal to or greater than 200 mcg/mL nitrite-equivalent cutoff, an equal to or greater than 50 mcg/mL chromium (VI)-equivalent cutoff, or a halogen concentration is equal to or greater than the LOQ) for both the initial (first) test and the second test on two separate aliquots;

(h) The possible presence of a surfactant is determined by using the same surfactant colorimetric test with an equal to greater than 100 mcg/mL dodecylbenzene sulfonate-equivalent cutoff for both the initial (first) test and the second test on two separate aliquots or a foam/shake test for the initial test;

(i) Interference occurs on the initial drug tests on two separate aliquots (i.e., valid immunoassay or alternate technology initial drug test results cannot be obtained);

(j) Interference with the drug confirmatory assay occurs on two separate aliquots of the specimen and the laboratory is unable to identify the interfering substance;

(k) The physical appearance of the specimen (e.g., viscosity) is such that testing the specimen may damage the laboratory's instruments;

(l) The specimen has been tested and the appearances of the primary (A) and the split (B) specimens (e.g., color) are clearly different; or

(m) A specimen validity test (i.e., other than the tests listed above) on two separate aliquots of the specimen indicates that the specimen is not valid for testing.

## **Subpart D - Collectors**

### Section 4.1 Who may collect a specimen?

(a) A collector who has been trained to collect urine specimens in accordance with these Guidelines.

(b) The immediate supervisor of a federal employee donor may only collect that donor's specimen when no other collector is available. The supervisor must be a trained collector.

(c) The hiring official of a federal agency applicant may only collect that federal agency applicant's specimen when no other collector is available. The hiring official must be a trained collector.

### Section 4.2 Who may not collect a specimen?

(a) A federal agency employee who is in a testing designated position and subject to the federal agency drug testing rules must not be a collector for co-workers in the same testing pool or who work with that employee on a daily basis.

(b) A federal agency applicant or employee must not collect their own drug testing specimen.

(c) An employee working for an HHS-certified laboratory or IITF must not act as a collector if the employee could link the identity of the donor to the donor's drug test result.

(d) To avoid a potential conflict of interest, a collector must not be related to the employee (e.g., spouse, ex-spouse, relative) or personal friend (e.g., fiancée).

### Section 4.3 What are the requirements to be a collector?

(a) An individual may serve as a collector if they fulfill the following conditions:

(1) Is knowledgeable about the collection procedure described in these Guidelines;

(2) Is knowledgeable about any guidance provided by the federal agency's Drug-Free Workplace Program and additional information provided by the Secretary relating to the collection procedure described in these Guidelines;

(3) Is trained and qualified to collect a urine specimen. Training must include the following:

- (i) All steps necessary to complete a urine collection;
- (ii) Completion and distribution of the Federal CCF;
- (iii) Problem collections;
- (iv) Fatal flaws, correctable flaws, and how to correct problems in collections; and
- (v) The collector's responsibility for maintaining the integrity of the collection process, ensuring the privacy of the donor, ensuring the security of the specimen, and avoiding conduct or statements that could be viewed as offensive or inappropriate.

(4) Has demonstrated proficiency in collections by completing five consecutive error-free mock collections.

(i) The five mock collections must include one uneventful collection scenario, one insufficient specimen quantity scenario, one temperature out of range scenario, one scenario in which the donor refuses to sign the Federal CCF, and one scenario in which the donor refuses to initial the specimen bottle tamper-evident seal.

(ii) A qualified trainer for collectors must monitor and evaluate the individual being trained, in person or by a means that provides real-time observation and interaction between the trainer and the trainee, and the trainer must attest in writing that the mock collections are error-free.

(b) A trained collector must complete refresher training at least every five years that includes the requirements in paragraph (a) of this section.

(c) The collector must maintain the documentation of their training and provide that documentation to a federal agency when requested.

(d) An individual may not collect specimens for a federal agency until the individual's training as a collector has been properly documented.

#### Section 4.4 What are the requirements to be an observer for a direct observed collection?

(a) An individual may serve as an observer for a direct observed collection when the individual has satisfied the requirements:

(1) Is knowledgeable about the direct observed collection procedure described in Section 8.9 of these Guidelines;

(2) Is knowledgeable about any guidance provided by the federal agency's Drug-Free Workplace Program or additional information provided by the Secretary relating to the direct observed collection procedure described in these Guidelines;

(3) Has received training on the following subjects:

(i) All steps necessary to perform a direct observed collection; and

(ii) The observer's responsibility for maintaining the integrity of the collection process, ensuring the privacy of individuals being tested, ensuring that the observation is done in a professional manner that minimizes the discomfort to the employee so observed, ensuring the security of the specimen by maintaining visual contact with the collection container until it is delivered to the collector, and avoiding conduct or statements that could be viewed as offensive or inappropriate.

(b) The gender of the observer must be the same as the donor's gender, which is determined by the donor's gender identity. The observer selection process is described in Section 8.10(b).

(c) The observer is not required to be a trained collector.

#### Section 4.5 What are the requirements to be a trainer for collectors?

(a) Individuals are considered qualified trainers for collectors and may train others to

collect urine specimens when they have completed the following:

(1) Qualified as a trained collector and regularly conducted urine drug test collections for a period of at least one year; or

(2) Completed a “train the trainer” course given by an organization (e.g., manufacturer, private entity, contractor, federal agency).

(b) A qualified trainer for collectors must complete refresher training at least every five years in accordance with the collector requirements in Section 4.3(a).

(c) A qualified trainer for collectors must maintain the documentation of the trainer’s training and provide that documentation to a federal agency when requested.

#### Section 4.6 What must a federal agency do before a collector is permitted to collect a specimen?

A federal agency must ensure the following:

(a) The collector has satisfied the requirements described in Section 4.3;

(b) The collector, who may be self-employed, or an organization (e.g., third party administrator that provides a collection service, collector training company, federal agency that employs its own collectors) maintains a copy of the training record(s); and

(c) The collector has been provided the name and telephone number of the federal agency representative.

### **Subpart E - Collection Sites**

#### Section 5.1 Where can a collection for a drug test take place?

(a) A collection site may be a permanent or temporary facility located either at the work site or at a remote site.

(b) In the event that an agency-designated collection site is not accessible and there is an

immediate requirement to collect a urine specimen (e.g., an accident investigation), a public restroom may be used for the collection, using the procedures for a monitored collection described in Section 8.12.

#### Section 5.2 What are the requirements for a collection site?

The facility used as a collection site must have the following:

- (a) Provisions to ensure donor privacy during the collection (as described in Section 8.1);
- (b) A suitable and clean surface area that is not accessible to the donor for handling the specimens and completing the required paperwork;
- (c) A secure temporary storage area to maintain specimens until the specimen is transferred to an HHS-certified laboratory or IITF;
- (d) A restricted access area where only authorized personnel may be present during the collection;
- (e) A restricted access area for the storage of collection supplies;
- (f) The ability to store records securely; and
- (g) The ability to restrict the donor access to potential diluents in accordance with Section 8.2.

#### Section 5.3 Where must collection site records be stored?

Collection site records must be stored at a secure site designated by the collector or the collector's employer.

#### Section 5.4 How long must collection site records be stored?

Collection site records (e.g., collector copies of the OMB-approved Federal CCF) must be stored securely for a minimum of 2 years. The collection site may convert hardcopy records to electronic records for storage and discard the hardcopy records after 6 months.

Section 5.5 How does the collector ensure the security and integrity of a specimen at the collection site?

(a) A collector must do the following to maintain the security and integrity of a specimen:

(1) Not allow unauthorized personnel to enter the collection area during the collection procedure;

(2) Perform only one donor collection at a time;

(3) Restrict access to collection supplies before, during, and after collection;

(4) Ensure that only the collector and the donor are allowed to handle the unsealed specimen;

(5) Ensure the chain of custody process is maintained and documented throughout the entire collection, storage, and transport procedures;

(6) Ensure that the Federal CCF is completed and distributed as required; and

(7) Ensure that specimens transported to an HHS-certified laboratory or IITF are sealed and placed in transport containers designed to minimize the possibility of damage during shipment (e.g., specimen boxes, padded mailers, or other suitable shipping container), and those containers are securely sealed to eliminate the possibility of undetected tampering;

(b) Couriers, express carriers, and postal service personnel are not required to document chain of custody since specimens are sealed in packages that would indicate tampering during transit to the HHS-certified laboratory or IITF.

Section 5.6 What are the privacy requirements when collecting a urine specimen?

Collections must be performed at a site that provides reasonable privacy (as described in Section 8.1).

**Subpart F - Federal Drug Testing Custody and Control Form**

### Section 6.1 What federal form is used to document custody and control?

The OMB-approved Federal CCF must be used to document custody and control of each specimen at the collection site.

### Section 6.2 What happens if the correct OMB-approved Federal CCF is not available or is not used?

(a) The use of a non-federal CCF or an expired Federal CCF is not, by itself, a reason for the HHS-certified laboratory or IITF to automatically reject the specimen for testing or for the MRO to cancel the test.

(b) If the collector does not use the correct OMB-approved Federal CCF, the collector must document that it is a federal agency specimen collection and provide the reason that the incorrect form was used. Based on the information provided by the collector, the HHS-certified laboratory or IITF must handle and test the specimen as a federal agency specimen.

(c) If the HHS-certified laboratory, HHS-certified IITF, or MRO discovers that the collector used an incorrect form, the laboratory, IITF, or MRO must obtain a memorandum for the record from the collector describing the reason the incorrect form was used. If a memorandum for the record cannot be obtained, the laboratory or IITF reports a rejected for testing result to the MRO and the MRO cancels the test. The HHS-certified laboratory or IITF must wait at least 5 business days while attempting to obtain the memorandum before reporting a rejected for testing result to the MRO.

## **Subpart G – Urine Specimen Collection Containers and Bottles**

### Section 7.1 What is used to collect a urine specimen?

A single-use collection container with a means (i.e., thermometer) to measure urine temperature and two specimen bottles must be used.

Section 7.2 What are the requirements for a urine collection container and specimen bottles?

(a) The collection container, the thermometer, and the specimen bottles must not substantially affect the composition of drugs and/or metabolites in the urine specimen.

(b) The two specimen bottles must be sealable and non-leaking, and must maintain the integrity of the specimen during storage and transport so that the specimen contained therein can be tested in an HHS-certified laboratory or IITF for the presence of drugs or their metabolites.

(c) The two specimen bottles must be sufficiently transparent to enable an objective assessment of specimen appearance and identification of abnormal physical characteristics without opening the bottle.

Section 7.3 What are the minimum performance requirements for a urine collection container and specimen bottles?

(a) The collection container must be capable of holding at least 55 mL and have a volume marking clearly noting a level of 45 mL.

(b) One of the two specimen bottles must be capable of holding at least 35 mL and the other at least 20 mL, and each must have a volume marking clearly noting the appropriate level (30 mL for the primary specimen and 15 mL for the split specimen).

(c) The thermometer may be affixed to or built into the collection container and must provide graduated temperature readings from 32–38 °C/90–100 °F. Alternatively, the collector may use another technology to measure specimen temperature (e.g., thermal radiation scanning), providing the thermometer does not come into contact with the specimen.

**Subpart H - Urine Specimen Collection Procedure**

### Section 8.1 What privacy must the donor be given when providing a urine specimen?

The following privacy requirements apply when a donor is providing a urine specimen:

(a) Only authorized personnel and the donor may be present in the restricted access area where the collection takes place.

(b) The collector is not required to be the same gender as the donor. The gender of the observer for purposes of a direct observed collection (i.e., as described in Section 8.10) must be the same as the donor's gender, which is determined by the donor's gender identity. The gender of the monitor for a monitored collection (i.e., as described in Section 8.12) must be the same as the donor's gender, unless the monitor is a medical professional (e.g., nurse, doctor, physician's assistant, technologist, or technician licensed or certified to practice in the jurisdiction in which the collection takes place).

(c) The collector must give the donor visual privacy while providing the specimen. The donor is allowed to provide a urine specimen in an enclosed stall within a multi-stall restroom or in a single person restroom during a monitored collection.

### Section 8.2 What must the collector ensure at the collection site before starting a urine specimen collection?

The collector must deter the dilution or substitution of a specimen at the collection site by:

(a) Placing a toilet bluing agent in a toilet bowl or toilet tank, so the reservoir of water in the toilet bowl always remains blue. If no bluing agent is available or if the toilet has an automatic flushing system, the collector shall turn the water supply off to the toilet and flush the toilet to remove the water in the toilet when possible.

(b) Secure other sources of water (e.g., shower or sink) in the enclosure where urination occurs. If the enclosure has a source of water that cannot be disabled or secured, a monitored

collection must be conducted in accordance with Section 8.11.

Section 8.3 What are the preliminary steps in the urine specimen collection procedure?

The collector must take the following steps before beginning a urine specimen collection:

(a) If a donor fails to arrive at the collection site at the assigned time, the collector must follow the federal agency policy or contact the federal agency representative to obtain guidance on action to be taken.

(b) When the donor arrives at the collection site, the collector should begin the collection procedure without undue delay. For example, the collection should not be delayed because the donor states that they are unable to urinate or an authorized employer or employer representative is late in arriving.

(c) The collector requests the donor to present photo identification (e.g., driver's license; employee badge issued by the employer; an alternative photo identification issued by a federal, state, or local government agency). If the donor does not have proper photo identification, the collector shall contact the supervisor of the donor or the federal agency representative who can positively identify the donor. If the donor's identity cannot be established, the collector must not proceed with the collection.

(d) The collector must provide identification (e.g., employee badge, employee list) if requested by the donor.

(e) The collector explains the basic collection procedure to the donor.

(f) The collector provides the instructions for completing the Federal CCF for the donor's review, and informs the donor that the instructions are available upon request.

(g) The collector answers any reasonable and appropriate questions the donor may have regarding the collection procedure.

(h) The collector asks the donor to remove any unnecessary outer garments (e.g., coat, jacket) that might conceal items or substances that could be used to adulterate or substitute the

urine specimen. The collector must ensure that all personal belongings (e.g., purse or briefcase) remain with the outer garments. The donor may retain the donor's wallet.

(i) The collector asks the donor to empty the donor's pockets and display the contents to ensure no items are present that could be used to adulterate or substitute the specimen.

(1) If no items are present that can be used to adulterate, substitute, or dilute the specimen, the collector instructs the donor to return the items to their pockets and continues the collection procedure.

(2) If an item is present whose purpose is to adulterate, substitute, or dilute the specimen (e.g., a commercial drug culture product or other substance for which the donor has no reasonable explanation), this is considered a refusal to test. The collector must stop the collection and report the refusal to test as described in Section 8.13.

(3) If an item that could be used to adulterate, substitute, or dilute the specimen (e.g., common personal care products such as eyedrops, mouthwash, or hand sanitizer) appears to have been inadvertently brought to the collection site, the collector must secure the item and continue with the normal collection procedure.

(4) If the donor refuses to show the collector the items in their pockets, this is considered a refusal to test. The collector must stop the collection and report the refusal to test as described in Section 8.13.

(j) The collector shall instruct the donor to wash and dry the donor's hands prior to urination. After washing the donor's hands, the donor must remain in the presence of the collector and must not have access to any water fountain, faucet, soap dispenser, cleaning agent, or any other materials which could be used to adulterate or substitute the specimen.

(k) If the donor refuses to wash their hands when instructed by the collector, this is considered a "refusal to test." The collector must stop the collection and report the refusal to test as described in Section 8.13.

Section 8.4 What steps does the collector take in the collection procedure before the donor provides a urine specimen?

(a) The collector will provide or the donor may select a specimen collection container that is clean, unused, wrapped/sealed in original packaging and compliant with Subpart G. The specimen collection container package will be opened in view of the donor.

(b) The collector instructs the donor to provide the specimen in the privacy of a stall or otherwise partitioned area that allows for individual privacy. The collector directs the donor to provide a specimen of at least 45 mL, to not flush the toilet, and to return with the specimen as soon as the donor has completed the void.

(1) Except in the case of a direct observed collection (i.e., as described in Section 8.10) or a monitored collection (i.e., as described in Section 8.12), neither the collector nor anyone else may go into the room with the donor.

(2) The collector may set a reasonable time limit for specimen collection.

(c) The collector notes any unusual behavior or appearance of the donor on the Federal CCF. If the collector detects any conduct that clearly indicates an attempt to tamper with a specimen (e.g., substitute urine in plain view or an attempt to bring into the collection site an adulterant or urine substitute), the collector must report a refusal to test in accordance with Section 8.13.

Section 8.5 What steps does the collector take during and after the urine specimen collection procedure?

Integrity and Identity of the Specimen. The collector must take the following steps during and after the donor provides the urine specimen:

(a) The collector must inform the donor that, once the collection procedure has begun, the donor must remain at the collection site (i.e., in an area designated by the collector) until the collection is complete and that failure to follow these instructions will be reported as a refusal to

test. This includes the wait period (i.e., up to 3 hours) if needed to provide a sufficient specimen as described in step (f)(2) below and in Section 8.6.

(b) After providing the specimen, the donor gives the specimen collection container to the collector. Both the donor and the collector must keep the specimen container in view at all times until the collector seals the specimen bottles as described in Section 8.8.

(c) After the donor has given the specimen to the collector, whenever practical, the donor shall be allowed to wash the donor's hands and the donor may flush the toilet.

(d) The collector must measure the temperature of the specimen within 4 minutes of receiving the specimen from the donor. The collector records on the Federal CCF whether or not the temperature is in the acceptable range of 32°-38°C/90°-100°F.

(1) The temperature measuring device must accurately reflect the temperature of the specimen and not contaminate the specimen.

(2) If the temperature of the specimen is outside the range of 32°-38°C/90°-100°F, that is a reason to believe that the donor may have adulterated or substituted the specimen. Another specimen must be collected under direct observation in accordance with Section 8.9. The collector must forward both specimens (i.e., from the first and second collections) to an HHS-certified laboratory for testing and record a comment on the Federal CCF for each specimen.

(e) The collector must inspect the specimen to determine if there is any sign indicating that the specimen may not be a valid urine specimen (e.g., unusual color, presence of foreign objects or material, unusual odor).

(1) The collector notes any unusual finding on the Federal CCF. A specimen suspected of not being a valid urine specimen must be forwarded to an HHS-certified laboratory for testing.

(2) When there is any reason to believe that a donor may have adulterated or substituted the specimen, another specimen must be obtained as soon as possible under direct observation in accordance with Section 8.10. The collector must forward both specimens (i.e., from the first and second collections) to an HHS-certified laboratory for testing and record a comment on the

Federal CCF for each specimen.

(f) The collector must determine the volume of urine in the specimen container. The collector must never combine urine collected from separate voids to create a specimen.

(1) If the volume is at least 45 mL, the collector will proceed with steps described in Section 8.8.

(2) If the volume is less than 45 mL, the collector discards the specimen and immediately collects a second specimen using the same procedures as for the first specimen (including steps in paragraphs c and d of this section).

(i) The collector may give the donor a reasonable amount of liquid to drink for this purpose (e.g., an 8 ounce glass of water every 30 minutes, but not to exceed a maximum of 40 ounces over a period of 3 hours or until the donor has provided a sufficient urine specimen). However, the donor is not required to drink any fluids during this waiting time.

(ii) If the donor provides a sufficient urine specimen (i.e., at least 45 mL), the collector proceeds with steps described in Section 8.8.

(iii) If the employee has not provided a sufficient specimen (i.e., at least 45 mL) within three hours of the first unsuccessful attempt to provide the specimen, the collector records the reason for not collecting a urine specimen on the Federal CCF, notifies the federal agency's designated representative for authorization of an alternate specimen to be collected, and sends the appropriate copies of the Federal CCF to the MRO and to the federal agency's designated representative. The federal agency may choose to provide the collection site with a standard protocol to follow in lieu of requiring the collector to notify the agency's designated representative for authorization in each case. If an alternate specimen is authorized, the collector may begin the collection procedure for the alternate specimen (see Section 8.7) in accordance with the Mandatory Guidelines for Federal Workplace Drug Testing Programs using the alternative specimen.

(g) If the donor fails to remain present through the completion of the collection, declines

to have a direct observed collection as required in steps (d)(2) or (e)(2) above, refuses to provide a second specimen as required in step (f)(2) above, or refuses to provide an alternate specimen as authorized in step (f)(2)(iii) above, the collector stops the collection and reports the refusal to test in accordance with Section 8.13.

Section 8.6 What procedure is used when the donor states that they are unable to provide a urine specimen?

(a) If the donor states that they are unable to provide a urine specimen during the collection process, the collector requests that the donor enter the restroom (stall) and attempt to provide a urine specimen.

(b) The donor demonstrates their inability to provide a specimen when he or she comes out of the stall with an empty collection container.

(1) If the donor states that they could provide a specimen after drinking some fluids, the collector gives the donor a reasonable amount of liquid to drink for this purpose (e.g., an 8 ounce glass of water every 30 minutes, but not to exceed a maximum of 40 ounces over a period of 3 hours or until the donor has provided a sufficient urine specimen). If the donor simply needs more time before attempting to provide a urine specimen, the donor may choose not to drink any fluids during the 3 hour wait time.

(2) If the donor states that they are unable to provide a urine specimen, the collector records the reason for not collecting a urine specimen on the Federal CCF, notifies the federal agency's designated representative for authorization of an alternate specimen to be collected, and sends the appropriate copies of the Federal CCF to the MRO and to the federal agency's designated representative. The federal agency may choose to provide the collection site with a standard protocol to follow in lieu of requiring the collector to notify the agency's designated representative for authorization in each case. If an alternate specimen is authorized, the collector may begin the collection procedure for the alternate specimen (see Section 8.7) in accordance

with the Mandatory Guidelines for Federal Workplace Drug Testing Programs using the alternative specimen.

Section 8.7 If the donor is unable to provide a urine specimen, may another specimen type be collected for testing?

Yes, if the alternate specimen type is authorized by Mandatory Guidelines for Federal Workplace Drug Testing Programs and specifically authorized by the federal agency.

Section 8.8 How does the collector prepare the urine specimens?

- (a) All federal agency collections are to be split specimen collections.
- (b) The collector, in the presence of the donor, pours the urine from the collection container into two specimen bottles to be labeled “A” and “B”. The collector pours at least 30 mL of urine into Bottle A and at least 15 mL into Bottle B, and caps each bottle.
- (c) In the presence of the donor, the collector places a tamper-evident label/seal from the Federal CCF over each specimen bottle cap. The collector records the date of the collection on the tamper-evident labels/seals.
- (d) The collector instructs the donor to initial the tamper-evident labels/seals on each specimen bottle. If the donor refuses to initial the labels/seals, the collector notes the refusal on the Federal CCF and continues with the collection process.
- (e) The collector must ensure that all the information required on the Federal CCF is provided.
- (f) The collector asks the donor to read and sign a statement on the Federal CCF certifying that the specimens identified were collected from the donor. If the donor refuses to sign the certification statement, the collector notes the refusal on the Federal CCF and continues with the collection process.
- (g) The collector signs and prints their name on the Federal CCF, completes the Federal

CCF, and distributes the copies of the Federal CCF as required.

(h) The collector seals the specimens (Bottle A and Bottle B) in a package and, within 24 hours or during the next business day, sends them to the HHS-certified laboratory or IITF that will be testing the Bottle A urine specimen.

(i) If the specimen and Federal CCF are not immediately transported to an HHS-certified laboratory or IITF, they must remain under direct control of the collector or be appropriately secured under proper specimen storage conditions until transported.

(j) The collector must discard any urine left over in the collection container after both specimen bottles have been appropriately filled and sealed. There is one exception to this requirement: the collector may use excess urine to conduct clinical tests (e.g., protein, glucose) if the collection was conducted in conjunction with a physical examination required by federal agency regulation. Neither the collector nor anyone else may conduct further testing (such as specimen validity testing) on the excess urine.

#### Section 8.9 When is a direct observed collection conducted?

A direct observed collection procedure must be conducted when:

(a) The agency has authorized a direct observed collection because:

(1) The donor's previous drug test result was reported by an MRO as positive, adulterated, or substituted; or

(2) The HHS-certified laboratory reports to the MRO that a specimen is invalid, and the MRO reported to the agency that there was not a legitimate medical explanation for the result; or

(3) The MRO reported to the agency that the primary (A) specimen was positive, adulterated, or substituted but the test was cancelled because the split (B) specimen could not be tested or the split specimen failed to reconfirm the primary specimen result; or

(b) At the collection site, an immediate collection of a second urine specimen is required because:

(1) The temperature of the specimen collected during a routine collection is outside the acceptable temperature range; or

(2) The collector suspects that the donor has tampered with the specimen during a routine collection (e.g., abnormal physical characteristic such as unusual color and/or odor, and/or excessive foaming when shaken).

(c) The collector must contact a collection site supervisor to review and concur in advance with any decision by the collector to obtain a specimen under direct observation.

(d) If the donor declines to have a direct observed collection, the collector reports a refusal to test (i.e., as described in Section 8.13).

#### Section 8.10 How is a direct observed collection conducted?

(a) A direct observed collection procedure is the same as that for a routine collection, except an observer watches the donor urinate into the collection container. The observer's gender must be the same as the donor's gender, which is determined by the donor's gender identity, with no exception to this requirement.

(b) Before an observer is selected, the collector informs the donor that the gender of the observer will match the donor's gender, which is determined by the donor's gender identity (as defined in Section 1.5). The collector then selects the observer to conduct the observation:

(i) The collector asks the donor to identify the donor's gender on the Federal CCF and initial it.

(ii) The donor will then be provided an observer whose gender matches the donor's gender.

(iii) The collector documents the observer's name and gender on the Federal CCF.

(c) If there is no collector available of the same gender as the donor's gender, the collector or collection site supervisor shall select an observer trained in direct observed specimen collection as described in Section 4.4. The observer may be an individual that is not a trained

collector.

(d) At the point in a routine collection where the donor enters the restroom with the collection container, a direct observed collection includes the following additional steps:

- (1) The observer enters the restroom with the donor;
- (2) The observer must directly watch the urine go from the donor's body into the collection container (the use of mirrors or video cameras is not permitted);
- (3) The observer must not touch or handle the collection container unless the observer is also serving as the collector;
- (4) After the donor has completed urinating into the collection container:
  - (i) If the same person serves as the observer and collector, that person may receive the collection container from the donor while they are both in the restroom;
  - (ii) If the observer is not serving as the collector, the donor and observer leave the restroom and the donor hands the collection container directly to the collector. The observer must maintain visual contact of the collection container until the donor hands the container to the collector.
- (5) The collector checks the box for an observed collection on the Federal CCF and writes the name of the observer and the reason for an observed collection on the Federal CCF; and
- (6) The collector then continues with the routine collection procedure in Section 8.3.

#### Section 8.11 When is a monitored collection conducted?

(a) In the event that an agency-designated collection site is not available and there is an immediate requirement to collect a specimen (e.g., an accident investigation), a public restroom may be used for the collection, using the procedures for a monitored collection described in Section 8.12.

(b) If the enclosure used by the donor to provide a specimen has a source of water that

cannot be disabled or secured, a monitored collection must be conducted.

(c) If the donor declines to permit a collection to be monitored when required, the collector reports a refusal to test (i.e., as described in Section 8.13).

#### Section 8.12 How is a monitored collection conducted?

A monitored collection is the same as that for a routine collection, except that a monitor accompanies the donor into the restroom to check for signs that the donor may be tampering with the specimen. The monitor remains in the restroom, but outside the stall, while the donor is providing the specimen. A person of the same gender as the donor shall serve as the monitor, unless the monitor is a medical professional (e.g., nurse, doctor, physician's assistant, technologist, or technician licensed or certified to practice in the jurisdiction in which the collection takes place). The same procedures used for selecting an observer of the appropriate gender in Section 8.10(b) must be used to select the monitor for the purposes of Section 8.12, unless the monitor is a medical professional as described above. The monitor may be an individual other than the collector and need not be a qualified collector.

(a) The collector secures the restroom being used for the monitored collection so that no one except the employee and the monitor can enter the restroom until after the collection has been completed.

(b) The monitor enters the restroom with the donor.

(c) The monitor must not watch the employee urinate into the collection container. If the monitor hears sounds or makes other observations indicating an attempt by the donor to tamper with a specimen, there must be an additional collection under direct observation in accordance with Section 8.9.

(d) The monitor must not touch or handle the collection container unless the monitor is also the collector.

(e) After the donor has completed urinating into the collection container:

(1) If the same person serves as the monitor and collector, that person may receive the collection container from the donor while they are both in the restroom;

(2) If the monitor is not serving as the collector, the donor and monitor leave the restroom and the donor hands the collection container directly to the collector. The monitor must ensure that the employee takes the collection container directly to the collector as soon as the employee has exited the enclosure.

(f) If the monitor is not serving as the collector, the collector writes the name of the monitor on the Federal CCF.

(g) The collector then continues with the routine collection procedure in Section 8.3.

#### Section 8.13 How does the collector report a donor's refusal to test?

If there is a refusal to test as defined in Section 1.7, the collector stops the collection, discards any urine collected and reports the refusal to test by:

(a) Notifying the federal agency by means (e.g., telephone, e-mail, or secure fax) that ensures that the notification is immediately received,

(b) Documenting the refusal to test on the Federal CCF, and

(c) Sending all copies of the Federal CCF to the federal agency's designated representative.

#### Section 8.14 What are a federal agency's responsibilities for a collection site?

(a) A federal agency must ensure that collectors and collection sites satisfy all requirements in subparts D, E, F, G, and H.

(b) A federal agency (or only one federal agency when several agencies are using the same collection site) must inspect 5 percent or up to a maximum of 50 collection sites each year, selected randomly from those sites used to collect agency specimens (e.g., virtual, onsite, or self-evaluation).

(c) A federal agency must investigate reported collection site deficiencies (e.g., specimens reported “rejected for testing” by an HHS-certified laboratory or IITF) and take appropriate action which may include a collection site self-assessment (i.e., using the Collection Site Checklist for the Collection of Urine Specimens for Federal Agency Workplace Drug Testing Programs) or an inspection of the collection site. The inspections of these additional collection sites may be included in the 5 percent or maximum of 50 collection sites inspected annually.

## **Subpart I - HHS Certification of Laboratories and IITFs**

### Section 9.1 Who has the authority to certify laboratories and IITFs to test urine specimens for federal agencies?

(a) The Secretary has broad discretion to take appropriate action to ensure the full reliability and accuracy of drug testing and reporting, to resolve problems related to drug testing, and to enforce all standards set forth in these Guidelines. The Secretary has the authority to issue directives to any HHS-certified laboratory or IITF including suspending the use of certain analytical procedures when necessary to protect the integrity of the testing process; ordering any HHS-certified laboratory or IITF to undertake corrective actions to respond to material deficiencies identified by an inspection or through performance testing; ordering any HHS-certified laboratory or IITF to send specimens or specimen aliquots to another HHS-certified laboratory for retesting when necessary to ensure the accuracy of testing under these Guidelines; ordering the review of results for specimens tested under the Guidelines for private sector clients to the extent necessary to ensure the full reliability of drug testing for federal agencies; and ordering any other action necessary to address deficiencies in drug testing, analysis, specimen collection, chain of custody, reporting of results, or any other aspect of the certification program.

(b) A laboratory or IITF is prohibited from stating or implying that it is certified by HHS

under these Guidelines to test urine specimens for federal agencies unless it holds such certification.

#### Section 9.2 What is the process for a laboratory or IITF to become HHS-certified?

(a) A laboratory or IITF seeking HHS certification must:

(1) Submit a completed OMB-approved application form (i.e., the applicant laboratory or IITF provides detailed information on both the administrative and analytical procedures to be used for federally regulated specimens);

(2) Have its application reviewed as complete and accepted by HHS;

(3) Successfully complete the PT challenges in 3 consecutive sets of initial PT samples;

(4) Satisfy all the requirements for an initial inspection; and

(5) Receive notification of certification from the Secretary before testing specimens for federal agencies.

#### Section 9.3 What is the process for a laboratory or IITF to maintain HHS certification?

(a) To maintain HHS certification, a laboratory or IITF must:

(1) Successfully participate in both the maintenance PT and inspection programs (i.e., successfully test the required quarterly sets of maintenance PT samples, undergo an inspection 3 months after being certified, and undergo maintenance inspections at a minimum of every 6 months thereafter);

(2) Respond in an appropriate, timely, and complete manner to required corrective action requests if deficiencies are identified in the maintenance PT performance, during the inspections, operations, or reporting; and

(3) Satisfactorily complete corrective remedial actions, and undergo special inspection and special PT sets to maintain or restore certification when material deficiencies occur in either the PT program, inspection program, or in operations and reporting.

Section 9.4 What is the process when a laboratory or IITF does not maintain its HHS certification?

- (a) A laboratory or IITF that does not maintain its HHS certification must:
  - (1) Stop testing federally regulated specimens;
  - (2) Ensure the security of federally regulated specimens and records throughout the required storage period described in Sections 11.20, 11.21, 12.18, and 14.8;
  - (3) Ensure access to federally regulated specimens and records in accordance with Sections 11.23, 11.24, 12.20, 12.21, and Subpart P; and
  - (4) Follow the HHS suspension and revocation procedures when imposed by the Secretary, follow the HHS procedures in Subpart P that will be used for all actions associated with the suspension and/or revocation of HHS-certification.

Section 9.5 What are the qualitative and quantitative specifications of performance testing (PT) samples?

- (a) PT samples used to evaluate drug tests will be prepared using the following specifications:
  - (1) PT samples may contain one or more of the drugs and drug metabolites in the drug classes listed in the drug testing panel and must satisfy one of the following parameters:
    - (i) The concentration of a drug or metabolite will be at least 20 percent above the initial test cutoff for the drug or drug metabolite;
    - (ii) The concentration of a drug or metabolite may be as low as 40 percent of the confirmatory test cutoff when the PT sample is designated as a retest sample; or
    - (iii) The concentration of drug or metabolite may differ from 9.5(a)(1)(i) and 9.5(a)(1)(ii) for a special purpose.
  - (2) A PT sample may contain an interfering substance, an adulterant, or other substances

for special purposes, or may satisfy the criteria for a substituted specimen, dilute specimen, or invalid result.

(3) A negative PT sample will not contain a measurable amount of a target analyte.

(b) PT samples used to evaluate specimen validity tests shall satisfy, but are not limited to, one of the following criteria:

(1) The nitrite concentration will be at least 20 percent above the cutoff;

(2) The pH will be between 1.5 and 5.0 or between 8.5 and 12.5;

(3) The concentration of an oxidant will be at a level sufficient to challenge a laboratory's ability to identify and confirm the oxidant;

(4) The creatinine concentration will be between 0 and 20 mg/dL; or

(5) The specific gravity will be less than or equal to 1.0050 or between 1.0170 and 1.0230.

(c) For each PT cycle, the set of PT samples going to each HHS-certified laboratory or IITF will vary but, within each calendar year, each HHS-certified laboratory or IITF will analyze essentially the same total set of samples.

(d) The laboratory or IITF must (to the greatest extent possible) handle, test, and report a PT sample in a manner identical to that used for a donor specimen, unless otherwise specified.

#### Section 9.6 What are the PT requirements for an applicant laboratory?

(a) An applicant laboratory that seeks certification under these Guidelines must satisfy the following criteria on three consecutive sets of PT samples:

(1) Have no false positive results;

(2) Correctly identify, confirm, and report at least 90 percent of the total drug challenges over the three sets of PT samples;

(3) Correctly identify at least 80 percent of the drug challenges for each initial drug test over the three sets of PT samples;

(4) For the confirmatory drug tests, correctly determine the concentrations (i.e., no more than  $\pm 20$  percent or  $\pm 2$  standard deviations [whichever is larger] from the appropriate reference or peer group means) for at least 80 percent of the total drug challenges over the three sets of PT samples;

(5) For the confirmatory drug tests, do not obtain any drug concentration that differs by more than  $\pm 50$  percent from the appropriate reference or peer group mean;

(6) For each confirmatory drug test, correctly identify and determine the concentrations (i.e., no more than  $\pm 20$  percent or  $\pm 2$  standard deviations [whichever is larger] from the appropriate reference or peer group means) for at least 50 percent of the drug challenges for an individual drug over the three sets of PT samples;

(7) Correctly identify at least 80 percent of the total specimen validity testing challenges over the three sets of PT samples;

(8) Correctly identify at least 80 percent of the challenges for each individual specimen validity test over the three sets of PT samples;

(9) For quantitative specimen validity tests, obtain quantitative values for at least 80 percent of the total challenges over the three sets of PT samples that satisfy the following criteria:

(i) Nitrite and creatinine concentrations are no more than  $\pm 20$  percent or  $\pm 2$  standard deviations from the appropriate reference or peer group mean; and

(ii) pH values are no more than  $\pm 0.3$  pH units from the appropriate reference or peer group mean using a pH meter; and

(iii) Specific gravity values are no more than  $\pm 0.0003$  specific gravity units from the appropriate reference or peer group mean when the mean is less than 1.0100 and specific gravity values are no more than  $\pm 0.0004$  specific gravity units from the appropriate reference or peer group mean when the mean is equal to or greater than 1.0100;

(10) Do not obtain any quantitative value on a specimen validity test PT sample that

differs from the appropriate reference or peer group mean by more than  $\pm 50$  percent for nitrite and creatinine concentrations,  $\pm 0.8$  pH units using a pH meter,  $\pm 0.0006$  specific gravity units when the mean is less than 1.0100, or  $\pm 0.0007$  specific gravity units when the mean is equal to or greater than 1.0100; and

(11) Do not report any sample as adulterated with a compound that is not present in the sample, adulterated based on pH when the appropriate reference or peer group mean is within the acceptable pH range, substituted when the appropriate reference or peer group means for both creatinine and specific gravity are within the acceptable range, or substituted when the appropriate reference or peer group mean for a biomarker is within the acceptable range.

(b) Failure to satisfy these requirements will result in disqualification.

#### Section 9.7 What are the PT requirements for an HHS-certified urine laboratory?

(a) A laboratory certified under these Guidelines must satisfy the following criteria on the maintenance PT samples:

- (1) Have no false positive results;
- (2) Correctly identify, confirm, and report at least 90 percent of the total drug challenges over two consecutive PT cycles;
- (3) Correctly identify at least 80 percent of the drug challenges for each initial drug test over two consecutive PT cycles;
- (4) For the confirmatory drug tests, correctly determine that the concentrations for at least 80 percent of the total drug challenges are no more than  $\pm 20$  percent or  $\pm 2$  standard deviations (whichever is larger) from the appropriate reference or peer group means over two consecutive PT cycles;
- (5) For the confirmatory drug tests, do not obtain any drug concentration that differs by more than  $\pm 50$  percent from the appropriate reference or peer group mean;
- (6) For each confirmatory drug test, correctly identify and determine that the

concentrations for at least 50 percent of the drug challenges for an individual drug are no more than  $\pm 20$  percent or  $\pm 2$  standard deviations (whichever is larger) from the appropriate reference or peer group means over two consecutive PT cycles;

(7) Correctly identify at least 80 percent of the total specimen validity testing challenges over two consecutive PT cycles;

(8) Correctly identify at least 80 percent of the challenges for each individual specimen validity test over two consecutive PT cycles;

(9) For quantitative specimen validity tests, obtain quantitative values for at least 80 percent of the total challenges over two consecutive PT cycles that satisfy the following criteria:

(i) Nitrite and creatinine concentrations are no more than  $\pm 20$  percent or  $\pm 2$  standard deviations from the appropriate reference or peer group mean;

(ii) pH values are no more than  $\pm 0.3$  pH units from the appropriate reference or peer group mean using a pH meter; and

(iii) Specific gravity values are no more than  $\pm 0.0003$  specific gravity units from the appropriate reference or peer group mean when the mean is less than 1.0100 and specific gravity values are no more than  $\pm 0.0004$  specific gravity units from the appropriate reference or peer group mean when the mean is equal to or greater than 1.0100;

(10) Do not obtain any quantitative value on a specimen validity test PT sample that differs from the appropriate reference or peer group mean by more than  $\pm 50$  percent for nitrite and creatinine concentrations,  $\pm 0.8$  pH units using a pH meter,  $\pm 0.0006$  specific gravity units when the mean is less than 1.0100, or  $\pm 0.0007$  specific gravity units when the mean is equal to or greater than 1.0100; and

(11) Do not report any PT sample as adulterated with a compound that is not present in the sample, adulterated based on pH when the appropriate reference or peer group mean is within the acceptable pH range, substituted when the appropriate reference or peer group means for both creatinine and specific gravity are within the acceptable range, or substituted when the

appropriate reference or peer group mean for a biomarker is within the acceptable range.

(b) Failure to participate in all PT cycles or to satisfy these requirements may result in suspension or revocation of an HHS-certified laboratory's certification.

#### Section 9.8 What are the PT requirements for an applicant IITF?

(a) An applicant IITF that seeks certification under these Guidelines must satisfy the following criteria on three consecutive sets of PT samples:

(1) Correctly identify at least 90 percent of the total drug challenges over the three sets of PT samples;

(2) Correctly identify at least 80 percent of the drug challenges for each individual drug test over the three sets of PT samples;

(3) Correctly identify at least 80 percent of the total specimen validity test challenges over the three sets of PT samples;

(4) Correctly identify at least 80 percent of the challenges for each individual specimen validity test over the three sets of PT samples;

(5) For quantitative specimen validity tests, obtain quantitative values for at least 80 percent of the total specimen validity test challenges over the three sets of PT samples that satisfy the following criteria:

(i) Creatinine concentrations are no more than  $\pm 20$  percent or  $\pm 2$  standard deviations (whichever is larger) from the appropriate reference or peer group mean; and

(ii) Specific gravity values are no more than  $\pm 0.001$  specific gravity units from the appropriate reference or peer group mean; and

(6) Must not obtain any quantitative value on a specimen validity test PT sample that differs from the appropriate reference or peer group mean by more than  $\pm 50$  percent for creatinine concentration or  $\pm 0.002$  specific gravity units for specific gravity.

(b) Failure to satisfy these requirements will result in disqualification.

Section 9.9 What are the PT requirements for an HHS-certified IITF?

(a) An IITF certified under these Guidelines must satisfy the following criteria on the maintenance PT samples to maintain its certification:

(1) Correctly identify at least 90 percent of the total drug challenges over two consecutive PT cycles;

(2) Correctly identify at least 80 percent of the drug challenges for each individual drug test over two consecutive PT cycles;

(3) Correctly identify at least 80 percent of the total specimen validity test challenges over two consecutive PT cycles;

(4) Correctly identify at least 80 percent of the challenges for each individual specimen validity test over two consecutive PT cycles;

(5) For quantitative specimen validity tests, obtain quantitative values for at least 80 percent of the total specimen validity test challenges over two consecutive PT cycles that satisfy the following criteria:

(i) Creatinine concentrations are no more than  $\pm 20$  percent or  $\pm 2$  standard deviations (whichever is larger) from the appropriate reference or peer group mean; and

(ii) Specific gravity values are no more than  $\pm 0.001$  specific gravity units from the appropriate reference or peer group mean; and

(6) Must not obtain any quantitative value on a specimen validity test PT sample that differs from the appropriate reference or peer group mean by more than  $\pm 50$  percent for creatinine concentration, or  $\pm 0.002$  specific gravity units for specific gravity.

(b) Failure to participate in all PT cycles or to satisfy these requirements may result in suspension or revocation of an HHS-certified IITF's certification.

Section 9.10 What are the inspection requirements for an applicant laboratory or IITF?

- (a) An applicant laboratory or IITF is inspected by a team of two inspectors.
- (b) Each inspector conducts an independent review and evaluation of all aspects of the laboratory's or IITF's testing procedures and facilities using an inspection checklist.

Section 9.11 What are the maintenance inspection requirements for an HHS-certified laboratory or IITF?

- (a) An HHS-certified laboratory or IITF must undergo an inspection 3 months after becoming certified and at least every 6 months thereafter.
- (b) An HHS-certified laboratory or IITF is inspected by one or more inspectors. The number of inspectors is determined according to the number of specimens reviewed. Additional information regarding inspections is available from SAMHSA.
- (c) Each inspector conducts an independent evaluation and review of the HHS-certified laboratory's or IITF's procedures, records, and facilities using guidance provided by the Secretary.
- (d) To remain certified, an HHS-certified laboratory or IITF must continue to satisfy the minimum requirements as stated in these Guidelines.

Section 9.12 Who can inspect an HHS-certified laboratory or IITF and when may the inspection be conducted?

- (a) An individual may be selected as an inspector for the Secretary if they satisfy the following criteria:
  - (1) Has experience and an educational background similar to that required for either a responsible person or a certifying scientist for an HHS-certified laboratory as described in Subpart K or as a responsible technician for an HHS-certified IITF as described in Subpart L;
  - (2) Has read and thoroughly understands the policies and requirements contained in these

Guidelines and in other guidance consistent with these Guidelines provided by the Secretary;

- (3) Submits a resume and documentation of qualifications to HHS;
  - (4) Attends approved training; and
  - (5) Performs acceptably as an inspector on an inspection of an HHS-certified laboratory or IITF.
- (b) The Secretary or a federal agency may conduct an inspection at any time.

Section 9.13 What happens if an applicant laboratory or IITF does not satisfy the minimum requirements for either the PT program or the inspection program?

If an applicant laboratory or IITF fails to satisfy the requirements established for the initial certification process, the laboratory or IITF must start the certification process from the beginning.

Section 9.14 What happens if an HHS-certified laboratory or IITF does not satisfy the minimum requirements for either the PT program or the inspection program?

(a) If an HHS-certified laboratory or IITF fails to satisfy the minimum requirements for certification, the laboratory or IITF is given a period of time (e.g., 5 or 30 working days depending on the nature of the deficiency) to provide any explanation for its performance and evidence that all deficiencies have been corrected.

(b) A laboratory's or IITF's HHS certification may be revoked, suspended, or no further action taken depending on the seriousness of the deficiencies and whether there is evidence that the deficiencies have been corrected and that current performance meets the requirements for certification.

(c) An HHS-certified laboratory or IITF may be required to undergo a special inspection or to test additional PT samples to address deficiencies.

(d) If an HHS-certified laboratory's or IITF's certification is revoked or suspended in

accordance with the process described in Subpart P, the laboratory or IITF is not permitted to test federally regulated specimens until the suspension is lifted or the laboratory or IITF has successfully completed the certification requirements as a new applicant laboratory or IITF.

Section 9.15 What factors are considered in determining whether revocation of a laboratory's or IITF's HHS certification is necessary?

(a) The Secretary shall revoke certification of an HHS-certified laboratory or IITF in accordance with these Guidelines if the Secretary determines that revocation is necessary to ensure fully reliable and accurate drug and specimen validity test results and reports.

(b) The Secretary shall consider the following factors in determining whether revocation is necessary:

(1) Unsatisfactory performance in analyzing and reporting the results of drug and specimen validity tests (e.g., an HHS-certified laboratory reporting a false positive result for an employee's drug test);

(2) Unsatisfactory participation in performance testing or inspections;

(3) A material violation of a certification standard, contract term, or other condition imposed on the HHS-certified laboratory or IITF by a federal agency using the laboratory's or IITF's services;

(4) Conviction for any criminal offense committed as an incident to operation of the HHS-certified laboratory or IITF; or

(5) Any other cause that materially affects the ability of the HHS-certified laboratory or IITF to ensure fully reliable and accurate drug test results and reports.

(c) The period and terms of revocation shall be determined by the Secretary and shall depend upon the facts and circumstances of the revocation and the need to ensure accurate and reliable drug testing.

Section 9.16 What factors are considered in determining whether to suspend a laboratory's or IITF's HHS certification?

(a) The Secretary may immediately suspend (either partially or fully) a laboratory's or IITF's HHS certification to conduct drug testing for federal agencies if the Secretary has reason to believe that revocation may be required and that immediate action is necessary to protect the interests of the United States and its employees.

(b) The Secretary shall determine the period and terms of suspension based upon the facts and circumstances of the suspension and the need to ensure accurate and reliable drug testing.

Section 9.17 How does the Secretary notify an HHS-certified laboratory or IITF that action is being taken against the laboratory or IITF?

(a) When laboratory's or IITF's HHS certification is suspended or the Secretary seeks to revoke HHS certification, the Secretary shall immediately serve the HHS-certified laboratory or IITF with written notice of the suspension or proposed revocation by fax, mail, personal service, or registered or certified mail, return receipt requested. This notice shall state the following:

- (1) The reasons for the suspension or proposed revocation;
- (2) The terms of the suspension or proposed revocation; and
- (3) The period of suspension or proposed revocation.

(b) The written notice shall state that the laboratory or IITF will be afforded an opportunity for an informal review of the suspension or proposed revocation if it so requests in writing within 30 days of the date the laboratory or IITF received the notice, or if expedited review is requested, within 3 days of the date the laboratory or IITF received the notice. Subpart P contains detailed procedures to be followed for an informal review of the suspension or proposed revocation.

(c) A suspension must be effective immediately. A proposed revocation must be effective 30 days after written notice is given or, if review is requested, upon the reviewing

official's decision to uphold the proposed revocation. If the reviewing official decides not to uphold the suspension or proposed revocation, the suspension must terminate immediately and any proposed revocation shall not take effect.

(d) The Secretary will publish in the **Federal Register** the name, address, and telephone number of any HHS-certified laboratory or IITF that has its certification revoked or suspended under Section 9.13 or Section 9.14, respectively, and the name of any HHS-certified laboratory or IITF that has its suspension lifted. The Secretary shall provide to any member of the public upon request the written notice provided to a laboratory or IITF that has its HHS certification suspended or revoked, as well as the reviewing official's written decision which upholds or denies the suspension or proposed revocation under the procedures of Subpart P.

Section 9.18 May a laboratory or IITF that had its HHS certification revoked be recertified to test federal agency specimens?

Following revocation, a laboratory or IITF may apply for recertification. Unless otherwise provided by the Secretary in the notice of revocation under Section 9.17 or the reviewing official's decision under Section 16.9(e) or 16.14(a), a laboratory or IITF which has had its certification revoked may reapply for HHS certification as an applicant laboratory or IITF.

Section 9.19 Where is the list of HHS-certified laboratories and IITFs published?

(a) The list of HHS-certified laboratories and IITFs is published monthly in the **Federal Register**. This notification is also available on the Internet at <http://www.samhsa.gov/workplace>.

(b) An applicant laboratory or IITF is not included on the list.

**Subpart J - Blind Samples Submitted by an Agency**

Section 10.1 What are the requirements for federal agencies to submit blind samples to HHS-certified laboratories or IITFs?

(a) Each federal agency is required to submit blind samples for its workplace drug testing program. The collector must send the blind samples to the HHS-certified laboratory or IITF that the collector sends employee specimens.

(b) Each federal agency must submit at least 3 percent blind samples along with its donor specimens based on the projected total number of donor specimens collected per year (up to a maximum of 400 blind samples). Every effort should be made to ensure that blind samples are submitted quarterly.

(c) Approximately 75 percent of the blind samples submitted each year by an agency must be negative, 15 percent must be positive for one or more drugs, and 10 percent must either be adulterated or substituted.

Section 10.2 What are the requirements for blind samples?

(a) Drug positive blind samples must be validated by the supplier as to their content using appropriate initial and confirmatory tests.

(1) Drug positive blind samples must be fortified with one or more of the drugs or metabolites listed in the drug testing panel.

(2) Drug positive blind samples must contain concentrations of drugs between 1.5 and 2 times the initial drug test cutoff.

(b) Drug negative blind samples (i.e., certified to contain no drugs) must be validated by the supplier as negative using appropriate initial and confirmatory tests.

(c) A blind sample that is adulterated must be validated using appropriate initial and confirmatory specimen validity tests, and have the characteristics to clearly show that it is an adulterated sample at the time of validation.

(d) A blind sample that is substituted must be validated using appropriate initial and confirmatory specimen validity tests, and have the characteristics to clearly show that it is a substituted sample at the time of validation.

(e) The supplier must provide information on the blind samples' content, validation, expected results, and stability to the collection site/collector sending the blind samples to the laboratory or IITF, and must provide the information upon request to the MRO, the federal agency for which the blind sample was submitted, or the Secretary.

### Section 10.3 How is a blind sample submitted to an HHS-certified laboratory or IITF?

(a) A blind sample must be submitted as a split specimen (specimens A and B) with the current Federal CCF that the HHS-certified laboratory or IITF uses for donor specimens. The collector provides the required information to ensure that the Federal CCF has been properly completed and provides fictitious initials on the specimen label/seal. The collector must indicate that the specimen is a blind sample on the MRO copy where a donor would normally provide a signature.

(b) A collector should attempt to distribute the required number of blind samples randomly with donor specimens rather than submitting the full complement of blind samples as a single group.

### Section 10.4 What happens if an inconsistent result is reported for a blind sample?

If an HHS-certified laboratory or IITF reports a result for a blind sample that is inconsistent with the expected result (e.g., a laboratory or IITF reports a negative result for a blind sample that was supposed to be positive, a laboratory reports a positive result for a blind sample that was supposed to be negative):

(a) The MRO must contact the laboratory or IITF and attempt to determine if the laboratory or IITF made an error during the testing or reporting of the sample;

(b) The MRO must contact the blind sample supplier and attempt to determine if the supplier made an error during the preparation or transfer of the sample;

(c) The MRO must contact the collector and determine if the collector made an error when preparing the blind sample for transfer to the HHS-certified laboratory or IITF;

(d) If there is no obvious reason for the inconsistent result, the MRO must notify both the federal agency for which the blind sample was submitted and the Secretary; and

(e) The Secretary shall investigate the blind sample error. A report of the Secretary's investigative findings and the corrective action taken in response to identified deficiencies must be sent to the federal agency. The Secretary shall ensure notification of the finding as appropriate to other federal agencies and coordinate any necessary actions to prevent the recurrence of the error.

## **Subpart K - Laboratory**

### Section 11.1 What must be included in the HHS-certified laboratory's standard operating procedure manual?

(a) An HHS-certified laboratory must have a standard operating procedure (SOP) manual that describes, in detail, all HHS-certified laboratory operations. When followed, the SOP manual ensures that all specimens are tested using the same procedures.

(b) The SOP manual must include at a minimum, but is not limited to, a detailed description of the following:

- (1) Chain of custody procedures;
- (2) Accessioning;
- (3) Security;
- (4) Quality control/quality assurance programs;
- (5) Analytical methods and procedures;

- (6) Equipment and maintenance programs;
- (7) Personnel training;
- (8) Reporting procedures; and
- (9) Computers, software, and laboratory information management systems.

(c) All procedures in the SOP manual must be compliant with these Guidelines and all guidance provided by the Secretary.

(d) A copy of all procedures that have been replaced or revised and the dates on which the procedures were in effect must be maintained for at least 2 years.

#### Section 11.2 What are the responsibilities of the responsible person (RP)?

(a) Manage the day-to-day operations of the HHS-certified laboratory even if another individual has overall responsibility for alternate areas of a multi-specialty laboratory.

(b) Ensure that there are sufficient personnel with adequate training and experience to supervise and conduct the work of the HHS-certified laboratory. The RP must ensure the continued competency of laboratory staff by documenting their in-service training, reviewing their work performance, and verifying their skills.

(c) Maintain a complete and current SOP manual that is available to all personnel of the HHS-certified laboratory and ensure that it is followed. The SOP manual must be reviewed, signed, and dated by the RP(s) when procedures are first placed into use and when changed or when a new individual assumes responsibility for the management of the HHS-certified laboratory. The SOP must be reviewed and documented by the RP annually.

(d) Maintain a quality assurance program that ensures the proper performance and reporting of all test results; verify and monitor acceptable analytical performance for all controls and calibrators; monitor quality control testing; and document the validity, reliability, accuracy, precision, and performance characteristics of each test and test system.

(e) Initiate and implement all remedial actions necessary to maintain satisfactory

operation and performance of the HHS-certified laboratory in response to the following: quality control systems not within performance specifications; errors in result reporting or in analysis of performance testing samples; and inspection deficiencies. The RP must ensure that specimen results are not reported until all corrective actions have been taken and that the results provided are accurate and reliable.

### Section 11.3 What scientific qualifications must the RP have?

The RP must have documented scientific qualifications in analytical toxicology.

Minimum qualifications are:

- (a) Certification or licensure as a laboratory director by the state in forensic or clinical laboratory toxicology, a Ph.D. in one of the natural sciences, or training and experience comparable to a Ph.D. in one of the natural sciences with training and laboratory/research experience in biology, chemistry, and pharmacology or toxicology;
- (b) Experience in forensic toxicology with emphasis on the collection and analysis of biological specimens for drugs of abuse;
- (c) Experience in forensic applications of analytical toxicology (e.g., publications, court testimony, conducting research on the pharmacology and toxicology of drugs of abuse) or qualify as an expert witness in forensic toxicology;
- (d) Fulfillment of the RP responsibilities and qualifications, as demonstrated by the HHS-certified laboratory's performance and verified upon interview by HHS-trained inspectors during each on-site inspection; and
- (e) Qualify as a certifying scientist.

### Section 11.4 What happens when the RP is absent or leaves an HHS-certified laboratory?

- (a) HHS-certified laboratories must have multiple RPs or one RP and an alternate RP. If the RP(s) are concurrently absent, an alternate RP must be present and qualified to fulfill the

responsibilities of the RP.

(1) If an HHS-certified laboratory is without the RP and alternate RP for 14 calendar days or less (e.g., temporary absence due to vacation, illness, or business trip), the HHS-certified laboratory may continue operations and testing of federal agency specimens under the direction of a certifying scientist.

(2) The Secretary, in accordance with these Guidelines, will suspend a laboratory's HHS certification for all specimens if the laboratory does not have an RP or alternate RP for a period of more than 14 calendar days. The suspension will be lifted upon the Secretary's approval of a new permanent RP or alternate RP.

(b) If the RP leaves an HHS-certified laboratory:

(1) The HHS-certified laboratory may maintain certification and continue testing federally regulated specimens under the direction of an alternate RP for a period of up to 180 days while seeking to hire and receive the Secretary's approval of the RP's replacement.

(2) The Secretary, in accordance with these Guidelines, will suspend a laboratory's HHS certification for all federally regulated specimens if the laboratory does not have a permanent RP within 180 days. The suspension will be lifted upon the Secretary's approval of the new permanent RP.

(c) To nominate an individual as an RP or alternate RP, the HHS-certified laboratory must submit the following documents to the Secretary: the candidate's current resume or curriculum vitae, copies of diplomas and licensures, a training plan (not to exceed 90 days) to transition the candidate into the position, an itemized comparison of the candidate's qualifications to the minimum RP qualifications described in the Guidelines, and have official academic transcript(s) submitted from the candidate's institution(s) of higher learning. The candidate must be found qualified during an on-site inspection of the HHS-certified laboratory.

(d) The HHS-certified laboratory must fulfill additional inspection and PT criteria as required prior to conducting federally regulated testing under a new RP.

Section 11.5 What qualifications must an individual have to certify a result reported by an HHS-certified laboratory?

(a) A certifying scientist must have:

(1) At least a bachelor's degree in the chemical or biological sciences or medical technology, or equivalent;

(2) Training and experience in the analytical methods and forensic procedures used by the HHS-certified laboratory relevant to the results that the individual certifies; and

(3) Training and experience in reviewing and reporting forensic test results and maintaining chain of custody, and an understanding of appropriate remedial actions in response to problems that may arise.

(b) A certifying technician must have:

(1) Training and experience in the analytical methods and forensic procedures used by the HHS-certified laboratory relevant to the results that the individual certifies; and

(2) Training and experience in reviewing and reporting forensic test results and maintaining chain of custody, and an understanding of appropriate remedial actions in response to problems that may arise.

Section 11.6 What qualifications and training must other personnel of an HHS-certified laboratory have?

(a) All HHS-certified laboratory staff (e.g., technicians, administrative staff) must have the appropriate training and skills for the tasks they perform.

(b) Each individual working in an HHS-certified laboratory must be properly trained (i.e., receive training in each area of work that the individual will be performing, including training in forensic procedures related to their job duties) before they are permitted to work independently with federally regulated specimens. All training must be documented.

Section 11.7 What security measures must an HHS-certified laboratory maintain?

- (a) An HHS-certified laboratory must control access to the drug testing facility, specimens, aliquots, and records.
- (b) Authorized visitors must be escorted at all times, except for individuals conducting inspections (i.e., for the Department, a federal agency, a state, or other accrediting agency) or emergency personnel (e.g., firefighters and medical rescue teams).
- (c) An HHS-certified laboratory must maintain records documenting the identity of the visitor and escort, date, time of entry and exit, and purpose for access to the secured area.

Section 11.8 What are the laboratory chain of custody requirements for specimens and aliquots?

- (a) HHS-certified laboratories must use chain of custody procedures (internal and external) to maintain control and accountability of specimens from the time of receipt at the laboratory through completion of testing, reporting of results, during storage, and continuing until final disposition of the specimens.
- (b) HHS-certified laboratories must use chain of custody procedures to document the handling and transfer of aliquots throughout the testing process until final disposal.
- (c) The chain of custody must be documented using either paper copy or electronic procedures.
- (d) Each individual who handles a specimen or aliquot must sign and complete the appropriate entries on the chain of custody form when the specimen or aliquot is handled or transferred, and every individual in the chain must be identified.
- (e) The date and purpose must be recorded on an appropriate chain of custody form each time a specimen or aliquot is handled or transferred.

Section 11.9 What test(s) does an HHS-certified laboratory conduct on a urine specimen

received from an IITF?

An HHS-certified laboratory must test the specimen in the same manner as a specimen that had not been previously tested.

Section 11.10 What are the requirements for an initial drug test?

(a) An initial drug test may be:

(1) An immunoassay; or

(2) An alternate technology (e.g., spectrometry, spectroscopy).

(b) An HHS-certified laboratory must validate an initial drug test before testing specimens.

(c) Initial drug tests must be accurate and reliable for the testing of specimens when identifying drugs or their metabolites.

(d) An HHS-certified laboratory may conduct a second initial drug test using a method with different specificity, to rule out cross-reacting compounds. This second initial drug test must satisfy the batch quality control requirements specified in Section 11.12.

Section 11.11 What must an HHS-certified laboratory do to validate an initial drug test?

(a) An HHS-certified laboratory must demonstrate and document the following for each initial drug test:

(1) The ability to differentiate negative specimens from those requiring further testing;

(2) The performance of the test around the cutoff, using samples at several concentrations between 0 and 150 percent of the cutoff;

(3) The effective concentration range of the test (linearity);

(4) The potential for carryover;

(5) The potential for interfering substances; and

(6) The potential matrix effects if using an alternate technology.

(b) Each new lot of reagent must be verified prior to being placed into service.

(c) Each initial drug test using an alternate technology must be re-verified periodically or at least annually.

Section 11.12 What are the batch quality control requirements when conducting an initial drug test?

(a) Each batch of specimens must contain the following controls:

(1) At least one control certified to contain no drug or drug metabolite;

(2) At least one positive control with the drug or drug metabolite targeted at a concentration 25 percent above the cutoff;

(3) At least one control with the drug or drug metabolite targeted at a concentration 75 percent of the cutoff; and

(4) At least one control that appears as a donor specimen to the analysts.

(b) Calibrators and controls must total at least 10 percent of the aliquots analyzed in each batch.

Section 11.13 What are the requirements for a confirmatory drug test?

(a) The analytical method must use mass spectrometric identification (e.g., gas chromatography/mass spectrometry [GC-MS], liquid chromatography-mass spectrometry [LC-MS], GC-MS/MS, LC-MS/MS) or equivalent.

(b) A confirmatory drug test must be validated before it can be used to test federally regulated specimens.

(c) Confirmatory drug tests must be accurate and reliable for the testing of a urine specimen when identifying and quantifying drugs or their metabolites.

Section 11.14 What must an HHS-certified laboratory do to validate a confirmatory drug test?

(a) An HHS-certified laboratory must demonstrate and document the following for each confirmatory drug test:

- (1) The linear range of the analysis;
- (2) The limit of detection;
- (3) The limit of quantification;
- (4) The accuracy and precision at the cutoff;
- (5) The accuracy (bias) and precision at 40 percent of the cutoff;
- (6) The potential for interfering substances;
- (7) The potential for carryover; and
- (8) The potential matrix effects if using liquid chromatography coupled with mass spectrometry.

(b) Each new lot of reagent must be verified prior to being placed into service.

(c) HHS-certified laboratories must re-verify each confirmatory drug test method periodically or at least annually.

Section 11.15 What are the batch quality control requirements when conducting a confirmatory drug test?

(a) At a minimum, each batch of specimens must contain the following calibrators and controls:

- (1) A calibrator at the cutoff;
- (2) At least one control certified to contain no drug or drug metabolite;
- (3) At least one positive control with the drug or drug metabolite targeted at 25 percent above the cutoff; and
- (4) At least one control targeted at or less than 40 percent of the cutoff.

(b) Calibrators and controls must total at least 10 percent of the aliquots analyzed in each batch.

Section 11.16 What are the analytical and quality control requirements for conducting specimen validity tests?

(a) Each invalid, adulterated, or substituted specimen validity test result must be based on an initial specimen validity test on one aliquot and a confirmatory specimen validity test on a second aliquot;

(b) The HHS-certified laboratory must establish acceptance criteria and analyze calibrators and controls as appropriate to verify and document the validity of the test results (required specimen validity tests are addressed in Section 11.18); and

(c) Controls must be analyzed concurrently with specimens.

Section 11.17 What must an HHS-certified laboratory do to validate a specimen validity test?

An HHS-certified laboratory must demonstrate and document for each specimen validity test the appropriate performance characteristics of the test, and must re-verify the test periodically, or at least annually. Each new lot of reagent must be verified prior to being placed into service.

Section 11.18 What are the requirements for conducting each specimen validity test?

(a) The requirements for measuring creatinine concentration are as follows:

(1) The creatinine concentration must be measured to one decimal place on both the initial creatinine test and the confirmatory creatinine test;

(2) The initial creatinine test must have the following calibrators and controls:

(i) A calibrator at 2 mg/dL;

(ii) A control in the range of 1.0 mg/dL to 1.5 mg/dL;

(iii) A control in the range of 3 mg/dL to 20 mg/dL; and

(iv) A control in the range of 21 mg/dL to 25 mg/dL.

(3) The confirmatory creatinine test (performed on those specimens with a creatinine concentration less than 2 mg/dL on the initial test) must have the following calibrators and controls:

- (i) A calibrator at 2 mg/dL;
- (ii) A control in the range of 1.0 mg/dL to 1.5 mg/dL; and
- (iii) A control in the range of 3 mg/dL to 4 mg/dL.

(b) The requirements for measuring specific gravity are as follows:

(1) For specimens with initial creatinine test results greater than 5 mg/dL and less than 20 mg/dL, laboratories may perform a screening test using a refractometer that measures urine specific gravity to at least three decimal places to identify specific gravity values that are acceptable (equal to or greater than 1.003) or dilute (equal to or greater than 1.002 and less than 1.003). Specimens must be subjected to an initial specific gravity test using a four decimal place refractometer when the initial creatinine test result is less than or equal to 5 mg/dL or when the screening specific gravity test result using a three decimal place refractometer is less than 1.002.

(2) The screening specific gravity test must have the following calibrators and controls:

- (i) A calibrator or control at 1.000;
- (ii) One control targeted at 1.002;
- (iii) One control in the range of 1.004 to 1.018.

(3) For the initial and confirmatory specific gravity tests, the refractometer must report and display specific gravity to four decimal places. The refractometer must be interfaced with a laboratory information management system (LIMS), computer, and/or generate a paper copy of the digital electronic display to document the numerical values of the specific gravity test results;

(4) The initial and confirmatory specific gravity tests must have the following calibrators and controls:

- (i) A calibrator or control at 1.0000;
- (ii) One control targeted at 1.0020;

(iii) One control in the range of 1.0040 to 1.0180; and

(iv) One control equal to or greater than 1.0200 but not greater than 1.0250.

(c) Requirements for measuring pH are as follows:

(1) Colorimetric pH tests that have the dynamic range of 3 to 12 to support the 4 and 11 pH cutoffs and pH meters must be capable of measuring pH to one decimal place. Colorimetric pH tests, dipsticks, and pH paper (i.e., screening tests) that have a narrow dynamic range and do not support the cutoffs may be used only to determine if an initial pH specimen validity test must be performed;

(2) For the initial and confirmatory pH tests, the pH meter must report and display pH to at least one decimal place. The pH meter must be interfaced with a LIMS, computer, and/or generate a paper copy of the digital electronic display to document the numerical values of the pH test results;

(3) pH screening tests must have, at a minimum, the following controls:

(i) One control below the lower decision point in use;

(ii) One control between the decision points in use; and

(iii) One control above the upper decision point in use;

(4) An initial colorimetric pH test must have the following calibrators and controls:

(i) One calibrator at 4;

(ii) One calibrator at 11;

(iii) One control in the range of 3 to 3.8;

(iv) One control in the range 4.2 to 5;

(v) One control in the range of 5 to 9;

(vi) One control in the range of 10 to 10.8; and

(vii) One control in the range of 11.2 to 12;

(5) An initial pH meter test, if a pH screening test is not used, must have the following calibrators and controls:

- (i) One calibrator at 3;
  - (ii) One calibrator at 7;
  - (iii) One calibrator at 10;
  - (iv) One control in the range of 3 to 3.8;
  - (v) One control in the range 4.2 to 5;
  - (vi) One control in the range of 10 to 10.8; and
  - (vii) One control in the range of 11.2 to 12;
- (6) An initial pH meter test (if a pH screening test is used) or confirmatory pH meter test

must have the following calibrators and controls when the result of the preceding pH test indicates that the pH is below the lower decision point in use:

- (i) One calibrator at 4;
- (ii) One calibrator at 7;
- (iii) One control in the range of 3 to 3.8; and
- (iv) One control in the range 4.2 to 5; and

(7) An initial pH meter test (if a pH screening test is used) or confirmatory pH meter test must have the following calibrators and controls when the result of the preceding pH test indicates that the pH is above the upper decision point in use:

- (i) One calibrator at 7;
- (ii) One calibrator at 10;
- (iii) One control in the range of 10 to 10.8; and
- (iv) One control in the range of 11.2 to 12.

(d) Requirements for performing oxidizing adulterant tests are as follows:

(1) The initial test must include an appropriate calibrator at the cutoff specified in Sections 11.19(d)(2), (3), or (4) for the compound of interest, a control without the compound of interest (i.e., a certified negative control), and at least one control with one of the compounds of interest at a measurable concentration; and

(2) A confirmatory test for a specific oxidizing adulterant must use a different analytical method than that used for the initial test. Each confirmatory test batch must include an appropriate calibrator, a control without the compound of interest (i.e., a certified negative control), and a control with the compound of interest at a measurable concentration.

(e) The requirements for measuring the nitrite concentration are that the initial and confirmatory nitrite tests must have a calibrator at the cutoff, a control without nitrite (i.e., certified negative urine), one control in the range of 200 mcg/mL to 250 mcg/mL, and one control in the range of 500 mcg/mL to 625 mcg/mL.

Section 11.19 What are the requirements for an HHS-certified laboratory to report a test result?

(a) Laboratories must report a test result to the agency's MRO within an average of 5 working days after receipt of the specimen. Reports must use the Federal CCF and/or an electronic report. Before any test result can be reported, it must be certified by a certifying scientist or a certifying technician (as appropriate).

(b) A primary (A) specimen is reported negative when each initial drug test is negative or if the specimen is negative upon confirmatory drug testing, and the specimen does not meet invalid criteria as described in items (h)(1) through (h)(12) below.

(c) A primary (A) specimen is reported positive for a specific drug or drug metabolite when both the initial drug test is positive and the confirmatory drug test is positive in accordance with the cutoffs listed in the drug testing panel.

(d) A primary (A) urine specimen is reported adulterated when:

(1) The pH is less than 4 or equal to or greater than 11 using either a pH meter or a colorimetric pH test for the initial test on the first aliquot and a pH meter for the confirmatory test on the second aliquot;

(2) The nitrite concentration is equal to or greater than 500 mcg/mL using either a nitrite colorimetric test or a general oxidant colorimetric test for the initial test on the first aliquot and a

different confirmatory test (e.g., multi-wavelength spectrophotometry, ion chromatography, capillary electrophoresis) on the second aliquot;

(3) The presence of chromium (VI) is verified using either a general oxidant colorimetric test (with an equal to or greater than 50 mcg/mL chromium (VI)-equivalent cutoff) or a chromium (VI) colorimetric test (chromium (VI) concentration equal to or greater than 50 mcg/mL) for the initial test on the first aliquot and a different confirmatory test (e.g., multi-wavelength spectrophotometry, ion chromatography, atomic absorption spectrophotometry, capillary electrophoresis, inductively coupled plasma-mass spectrometry) with the chromium (VI) concentration equal to or greater than the LOQ of the confirmatory test on the second aliquot;

(4) The presence of halogen (e.g., chlorine from bleach, iodine, fluoride) is verified using either a general oxidant colorimetric test (with an equal to or greater than 200 mcg/mL nitrite-equivalent cutoff or an equal to or greater than 50 mcg/mL chromium (VI)-equivalent cutoff) or halogen colorimetric test (halogen concentration equal to or greater than the LOQ) for the initial test on the first aliquot and a different confirmatory test (e.g., multi-wavelength spectrophotometry, ion chromatography, inductively coupled plasma-mass spectrometry) with a specific halogen concentration equal to or greater than the LOQ of the confirmatory test on the second aliquot;

(5) The presence of glutaraldehyde is verified using either an aldehyde test (aldehyde present) or the characteristic immunoassay response on one or more drug immunoassay tests for the initial test on the first aliquot and a different confirmatory method (e.g., GC/MS) for the confirmatory test with the glutaraldehyde concentration equal to or greater than the LOQ of the analysis on the second aliquot;

(6) The presence of pyridine (pyridinium chlorochromate) is verified using either a general oxidant colorimetric test (with an equal to or greater than 200 mcg/mL nitrite-equivalent cutoff or an equal to or greater than 50 mcg/mL chromium (VI)-equivalent cutoff) or a

chromium (VI) colorimetric test (chromium (VI) concentration equal to or greater than 50 mcg/mL) for the initial test on the first aliquot and a different confirmatory method (e.g., GC/MS) for the confirmatory test with the pyridine concentration equal to or greater than the LOQ of the analysis on the second aliquot;

(7) The presence of a surfactant is verified by using a surfactant colorimetric test with an equal to or greater than 100 mcg/mL dodecylbenzene sulfonate-equivalent cutoff for the initial test on the first aliquot and a different confirmatory test (e.g., multi-wavelength spectrophotometry) with an equal to or greater than 100 mcg/mL dodecylbenzene sulfonate-equivalent cutoff on the second aliquot; or

(8) The presence of any other adulterant not specified in paragraphs (d)(2) through (d)(7) of this section is verified using an initial test on the first aliquot and a different confirmatory test on the second aliquot.

(e) A primary (A) urine specimen is reported substituted when:

(1) The creatinine concentration is less than 2 mg/dL and the specific gravity is less than or equal to 1.0010 or equal to or greater than 1.0200 on both the initial and confirmatory creatinine tests (i.e., the same colorimetric test may be used to test both aliquots) and on both the initial and confirmatory specific gravity tests (i.e., a refractometer is used to test both aliquots) on two separate aliquots; or

(2) A biomarker is not present or is present at a concentration inconsistent with that established for human urine.

(f) A primary (A) urine specimen is reported dilute when the creatinine concentration is equal to or greater than 2 mg/dL but less than 20 mg/dL and the specific gravity is greater than 1.0010 but less than 1.0030 on a single aliquot.

(g) For a specimen that has an invalid result for one of the reasons stated in items (h)(4) through (h)(13) below, the HHS-certified laboratory shall contact the MRO and both will decide if testing by another HHS-certified laboratory would be useful in being able to report a positive,

adulterated, or substituted result. If no further testing is necessary, the HHS-certified laboratory then reports the invalid result to the MRO.

(h) A primary (A) urine specimen is reported as an invalid result when:

(1) Inconsistent creatinine concentration and specific gravity results are obtained (i.e., the creatinine concentration is less than 2 mg/dL on both the initial and confirmatory creatinine tests and the specific gravity is greater than 1.0010 but less than 1.0200 on the initial and/or confirmatory specific gravity test, the specific gravity is less than or equal to 1.0010 on both the initial and confirmatory specific gravity tests and the creatinine concentration is equal to or greater than 2 mg/dL on either or both the initial or confirmatory creatinine tests);

(2) The pH is equal to or greater than 4 and less than 4.5 or equal to or greater than 9 and less than 11 using either a colorimetric pH test or pH meter for the initial test and a pH meter for the confirmatory test on two separate aliquots;

(3) The nitrite concentration is equal to or greater than 200 mcg/mL using a nitrite colorimetric test or equal to or greater than the equivalent of 200 mcg/mL nitrite using a general oxidant colorimetric test for both the initial (first) test and the second test or using either initial test and the nitrite concentration is equal to or greater than 200 mcg/mL but less than 500 mcg/mL for a different confirmatory test (e.g., multi-wavelength spectrophotometry, ion chromatography, capillary electrophoresis) on two separate aliquots;

(4) The possible presence of chromium (VI) is determined using the same chromium (VI) colorimetric test with a cutoff equal to or greater than 50 mcg/mL chromium (VI) for both the initial (first) test and the second test on two separate aliquots;

(5) The possible presence of a halogen (e.g., chlorine from bleach, iodine, fluoride) is determined using the same halogen colorimetric test with a cutoff equal to or greater than the LOQ for both the initial (first) test and the second test on two separate aliquots or relying on the odor of the specimen as the initial test;

(6) The possible presence of glutaraldehyde is determined by using the same aldehyde

test (aldehyde present) or characteristic immunoassay response on one or more drug immunoassay tests for both the initial (first) test and the second test on two separate aliquots;

(7) The possible presence of an oxidizing adulterant is determined by using the same general oxidant colorimetric test (with an equal to or greater than 200 mcg/mL nitrite-equivalent cutoff, an equal to or greater than 50 mcg/mL chromium (VI)-equivalent cutoff, or a halogen concentration is equal to or greater than the LOQ) for both the initial (first) test and the second test on two separate aliquots;

(8) The possible presence of a surfactant is determined by using the same surfactant colorimetric test with an equal to or greater than 100 mcg/mL dodecylbenzene sulfonate-equivalent cutoff for both the initial (first) test and the second test on two separate aliquots or a foam/shake test for the initial test;

(9) Interference occurs on the initial drug tests on two separate aliquots (i.e., valid initial drug test results cannot be obtained);

(10) Interference with the confirmatory drug test occurs on at least two separate aliquots of the specimen and the HHS-certified laboratory is unable to identify the interfering substance;

(11) The physical appearance of the specimen is such that testing the specimen may damage the laboratory's instruments;

(12) The physical appearances of the A and B specimens are clearly different (note: A is tested); or

(13) A specimen validity test (i.e., other than the tests listed above) on two separate aliquots of the specimen indicates that the specimen is not valid for testing.

(i) An HHS-certified laboratory shall reject a primary (A) specimen for testing when a fatal flaw occurs as described in Section 15.1 or when a correctable flaw as described in Section 15.2 is not recovered. The HHS-certified laboratory will indicate on the Federal CCF that the specimen was rejected for testing and provide the reason for reporting the rejected for testing result.

(j) An HHS-certified laboratory must report all positive, adulterated, substituted, and invalid test results for a urine specimen. For example, a specimen can be positive for a specific drug and adulterated.

(k) An HHS-certified laboratory must report the confirmatory concentration of each drug or drug metabolite reported for a positive result.

(l) An HHS-certified laboratory must report numerical values of the specimen validity test results that support a specimen that is reported adulterated, substituted, or invalid (as appropriate).

(m) An HHS-certified laboratory must report results using the HHS-specified nomenclature published with the drug and biomarker testing panels.

(n) When the concentration of a drug or drug metabolite exceeds the validated linear range of the confirmatory test, HHS-certified laboratories may report to the MRO that the quantitative value exceeds the linear range of the test or that the quantitative value is greater than “insert the actual value for the upper limit of the linear range,” or laboratories may report a quantitative value above the upper limit of the linear range that was obtained by diluting an aliquot of the specimen to achieve a result within the method’s linear range and multiplying the result by the appropriate dilution factor.

(o) HHS-certified laboratories may transmit test results to the MRO by various electronic means (e.g., teleprinter, fax, or computer). Transmissions of the reports must ensure confidentiality and the results may not be reported verbally by telephone. Laboratories and external service providers must ensure the confidentiality, integrity, and availability of the data and limit access to any data transmission, storage, and retrieval system.

(p) HHS-certified laboratories must fax, courier, mail, or electronically transmit a legible image or copy of the completed Federal CCF and/or forward a computer-generated electronic report. The computer-generated report must contain sufficient information to ensure that the test results can accurately represent the content of the custody and control form that the MRO

received from the collector.

(q) For positive, adulterated, substituted, invalid, and rejected specimens, laboratories must fax, courier, mail, or electronically transmit a legible image or copy of the completed Federal CCF.

#### Section 11.20 How long must an HHS-certified laboratory retain specimens?

(a) An HHS-certified laboratory must retain specimens that were reported as positive, adulterated, substituted, or as an invalid result for a minimum of 1 year.

(b) Retained specimens must be kept in secured frozen storage (-20°C or less) to ensure their availability for retesting during an administrative or judicial proceeding.

(c) Federal agencies may request that the HHS-certified laboratory retain a specimen for an additional specified period of time and must make that request within the 1-year period.

#### Section 11.21 How long must an HHS-certified laboratory retain records?

(a) An HHS-certified laboratory must retain all records generated to support test results for at least 2 years. The laboratory may convert hardcopy records to electronic records for storage and then discard the hardcopy records after 6 months.

(b) A federal agency may request the HHS-certified laboratory to maintain a documentation package (as described in Section 11.23) that supports the chain of custody, testing, and reporting of a donor's specimen that is under legal challenge by a donor. The federal agency's request to the laboratory must be in writing and must specify the period of time to maintain the documentation package.

(c) An HHS-certified laboratory may retain records other than those included in the documentation package beyond the normal 2-year period of time.

#### Section 11.22 What statistical summary reports must an HHS-certified laboratory provide for

urine testing?

(a) HHS-certified laboratories must provide to each federal agency for which they perform testing a semiannual statistical summary report that must be submitted by mail, fax, or e-mail within 14 working days after the end of the semiannual period. The summary report must not include any personally identifiable information. A copy of the semiannual statistical summary report will also be sent to the Secretary or designated HHS representative. The semiannual statistical report contains the following information:

- (1) Reporting period (inclusive dates);
- (2) HHS-certified laboratory name and address;
- (3) Federal agency name;
- (4) Number of specimen results reported;
- (5) Number of specimens collected by reason for test;
- (6) Number of specimens reported negative and the number reported negative/dilute;
- (7) Number of specimens rejected for testing because of a fatal flaw;
- (8) Number of specimens rejected for testing because of an uncorrected flaw;
- (9) Number of specimens tested positive by each initial drug test;
- (10) Number of specimens reported positive;
- (11) Number of specimens reported positive for each drug and drug metabolite;
- (12) Number of specimens reported adulterated;
- (13) Number of specimens reported substituted; and
- (14) Number of specimens reported as invalid result.

(b) An HHS-certified laboratory must make copies of an agency's test results available when requested to do so by the Secretary or by the federal agency for which the laboratory is performing drug-testing services.

(c) An HHS-certified laboratory must ensure that a qualified individual is available to testify in a proceeding against a federal employee when the proceeding is based on a test result

reported by the laboratory.

Section 11.23 What HHS-certified laboratory information is available to a federal agency?

(a) Following a federal agency's receipt of a positive, adulterated, or substituted drug test report, the federal agency may submit a written request for copies of the records relating to the drug test results or a documentation package or any relevant certification, review, or revocation of certification records.

(b) Standard documentation packages provided by an HHS-certified laboratory must contain the following items:

(1) A cover sheet providing a brief description of the procedures and tests performed on the donor's specimen;

(2) A table of contents that lists all documents and materials in the package by page number;

(3) A copy of the Federal CCF with any attachments, internal chain of custody records for the specimen, memoranda (if any) generated by the HHS-certified laboratory, and a copy of the electronic report (if any) generated by the HHS-certified laboratory;

(4) A brief description of the HHS-certified laboratory's initial drug and specimen validity testing procedures, instrumentation, and batch quality control requirements;

(5) Copies of the initial test data for the donor's specimen with all calibrators and controls and copies of all internal chain of custody documents related to the initial tests;

(6) A brief description of the HHS-certified laboratory's confirmatory drug (and specimen validity, if applicable) testing procedures, instrumentation, and batch quality control requirements;

(7) Copies of the confirmatory test data for the donor's specimen with all calibrators and controls and copies of all internal chain of custody documents related to the confirmatory tests; and

(8) Copies of the résumé or curriculum vitae for the RP(s) and the certifying technician or certifying scientist of record.

Section 11.24 What HHS-certified laboratory information is available to a federal employee?

A federal employee who is the subject of a workplace drug test may submit a written request through the MRO and/or the federal agency requesting copies of any records relating to the employee's drug test results or a documentation package as described in Section 11.23(b) and any relevant certification, review, or revocation of certification records. Federal employees, or their designees, are not permitted access to their specimens collected pursuant to Executive Order 12564, Public Law 100-71, and these Guidelines.

Section 11.25 What types of relationships are prohibited between an HHS-certified laboratory and an MRO?

An HHS-certified laboratory must not enter into any relationship with a federal agency's MRO that may be construed as a potential conflict of interest or derive any financial benefit by having a federal agency use a specific MRO.

This means an MRO may be an employee of the agency or a contractor for the agency; however, an MRO shall not be an employee or agent of or have any financial interest in the HHS-certified laboratory for which the MRO is reviewing drug testing results. Additionally, an MRO shall not derive any financial benefit by having an agency use a specific HHS-certified laboratory or have any agreement with an HHS-certified laboratory that may be construed as a potential conflict of interest.

Section 11.26 What type of relationship can exist between an HHS-certified laboratory and an HHS-certified IITF?

An HHS-certified laboratory can enter into any relationship with an HHS-certified IITF.

## **Subpart L - Instrumented Initial Test Facility (IITF)**

### Section 12.1 What must be included in the HHS-certified IITF's standard operating procedure manual?

(a) An HHS-certified IITF must have a standard operating procedure (SOP) manual that describes, in detail, all HHS-certified IITF operations. When followed, the SOP manual ensures that all specimens are tested consistently using the same procedures.

(b) The SOP manual must include at a minimum, but is not limited to, a detailed description of the following:

- (1) Chain of custody procedures;
- (2) Accessioning;
- (3) Security;
- (4) Quality control/quality assurance programs;
- (5) Analytical methods and procedures;
- (6) Equipment and maintenance programs;
- (7) Personnel training;
- (8) Reporting procedures; and
- (9) Computers, software, and laboratory information management systems.

(c) All procedures in the SOP manual must be compliant with these Guidelines and all guidance provided by the Secretary.

(d) A copy of all procedures that have been replaced or revised and the dates on which the procedures were in effect must be maintained for two years.

### Section 12.2 What are the responsibilities of the responsible technician (RT)?

- (a) Manage the day-to-day operations of the HHS-certified IITF even if another

individual has overall responsibility for alternate areas of a multi-specialty facility.

(b) Ensure that there are sufficient personnel with adequate training and experience to supervise and conduct the work of the HHS-certified IITF. The RT must ensure the continued competency of IITF personnel by documenting their in-service training, reviewing their work performance, and verifying their skills.

(c) Maintain a complete and current SOP manual that is available to all personnel of the HHS-certified IITF, and ensure that it is followed. The SOP manual must be reviewed, signed, and dated by the RT when procedures are first placed into use or changed or when a new individual assumes responsibility for the management of the HHS-certified IITF. The SOP must be reviewed and documented by the RT annually.

(d) Maintain a quality assurance program that ensures the proper performance and reporting of all test results; verify and monitor acceptable analytical performance for all controls and calibrators; monitor quality control testing; and document the validity, reliability, accuracy, precision, and performance characteristics of each test and test system.

(e) Initiate and implement all remedial actions necessary to maintain satisfactory operation and performance of the HHS-certified IITF in response to the following: quality control systems not within performance specifications, errors in result reporting or in analysis of performance testing samples, and inspection deficiencies. The RT must ensure that specimen results are not reported until all corrective actions have been taken and that the results provided are accurate and reliable.

### Section 12.3 What qualifications must the RT have?

An RT must:

(a) Have at least a bachelor's degree in the chemical or biological sciences or medical technology, or equivalent;

(b) Have training and experience in the analytical methods and forensic procedures used

by the HHS-certified IITF;

(c) Have training and experience in reviewing and reporting forensic test results and maintaining chain of custody, and an understanding of appropriate remedial actions in response to problems that may arise;

(d) Be found to fulfill RT responsibilities and qualifications, as demonstrated by the HHS-certified IITF's performance and verified upon interview by HHS-trained inspectors during each on-site inspection; and

(e) Qualify as a certifying technician.

#### Section 12.4 What happens when the RT is absent or leaves an HHS-certified IITF?

(a) HHS-certified IITFs must have an RT and an alternate RT. When an RT is absent, an alternate RT must be present and qualified to fulfill the responsibilities of the RT.

(1) If an HHS-certified IITF is without the RT and alternate RT for 14 calendar days or less (e.g., temporary absence due to vacation, illness, business trip), the HHS-certified IITF may continue operations and testing of federal agency specimens under the direction of a certifying technician.

(2) The Secretary, in accordance with these Guidelines, will suspend an IITF's HHS certification for all specimens if the IITF does not have an RT or alternate RT for a period of more than 14 calendar days. The suspension will be lifted upon the Secretary's approval of a new permanent RT or alternate RT.

(b) If the RT leaves an HHS-certified IITF:

(1) The HHS-certified IITF may maintain certification and continue testing federally regulated specimens under the direction of an alternate RT for a period of up to 180 days while seeking to hire and receive the Secretary's approval of the RT's replacement.

(2) The Secretary, in accordance with these Guidelines, will suspend an IITF's HHS certification for all federally regulated specimens if the IITF does not have a permanent RT

within 180 days. The suspension will be lifted upon the Secretary's approval of the new permanent RT.

(c) To nominate an individual as the RT or alternate RT, the HHS-certified IITF must submit the following documents to the Secretary: the candidate's current resume or curriculum vitae, copies of diplomas and licensures, a training plan (not to exceed 90 days) to transition the candidate into the position, an itemized comparison of the candidate's qualifications to the minimum RT qualifications described in the Guidelines, and have official academic transcript(s) submitted from the candidate's institution(s) of higher learning. The candidate must be found qualified during an on-site inspection of the HHS-certified IITF.

(d) The HHS-certified IITF must fulfill additional inspection and PT criteria as required prior to conducting federally regulated testing under a new RT.

#### Section 12.5 What qualifications must an individual have to certify a result reported by an HHS-certified IITF?

A certifying technician must have:

(a) Training and experience in the analytical methods and forensic procedures used by the HHS-certified IITF relevant to the results that the individual certifies; and

(b) Training and experience in reviewing and reporting forensic test results and maintaining chain of custody, and an understanding of appropriate remedial actions in response to problems that may arise.

#### Section 12.6 What qualifications and training must other personnel of an HHS-certified IITF have?

(a) All HHS-certified IITF staff (e.g., technicians, administrative staff) must have the appropriate training and skills for the tasks they perform.

(b) Each individual working in an HHS-certified IITF must be properly trained (i.e.,

receive training in each area of work that the individual will be performing, including training in forensic procedures related to their job duties) before they are permitted to work independently with federally regulated specimens. All training must be documented.

#### Section 12.7 What security measures must an HHS-certified IITF maintain?

- (a) An HHS-certified IITF must control access to the drug testing facility, specimens, aliquots, and records.
- (b) Authorized visitors must be escorted at all times except for individuals conducting inspections (i.e., for the Department, a federal agency, a state, or other accrediting agency) or emergency personnel (e.g., firefighters and medical rescue teams).
- (c) An HHS-certified IITF must maintain records documenting the identity of the visitor and escort, date, time of entry and exit, and purpose for the access to the secured area.

#### Section 12.8 What are the IITF chain of custody requirements for specimens and aliquots?

- (a) HHS-certified IITFs must use chain of custody procedures (internal and external) to maintain control and accountability of specimens from the time of receipt at the IITF through completion of testing, reporting of results, during storage, and continuing until final disposition of the specimens.
- (b) HHS-certified IITFs must use chain of custody procedures to document the handling and transfer of aliquots throughout the testing process until final disposal.
- (c) The chain of custody must be documented using either paper copy or electronic procedures.
- (d) Each individual who handles a specimen or aliquot must sign and complete the appropriate entries on the chain of custody form when the specimen or aliquot is handled or transferred, and every individual in the chain must be identified.
- (e) The date and purpose must be recorded on an appropriate chain of custody form each

time a specimen or aliquot is handled or transferred.

#### Section 12.9 What are the requirements for an initial drug test?

(a) An initial drug test may be:

(1) An immunoassay; or

(2) An alternate technology (e.g., spectrometry, spectroscopy).

(b) An HHS-certified IITF must validate an initial drug test before testing specimens;

(c) Initial drug tests must be accurate and reliable for the testing of urine specimens when identifying drugs or their metabolites.

(d) An HHS-certified IITF may conduct a second initial drug test using a method with different specificity, to rule out cross-reacting compounds. This second initial drug test must satisfy the batch quality control requirements specified in Section 12.11.

#### Section 12.10 What must an HHS-certified IITF do to validate an initial drug test?

(a) An HHS-certified IITF must demonstrate and document the following for each initial drug test:

(1) The ability to differentiate negative specimens from those requiring further testing;

(2) The performance of the test around the cutoff, using samples at several concentrations between 0 and 150 percent of the cutoff;

(3) The effective concentration range of the test (linearity);

(4) The potential for carryover;

(5) The potential for interfering substances; and

(6) The potential matrix effects if using an alternate technology.

(b) Each new lot of reagent must be verified prior to being placed into service.

(c) Each initial drug test using an alternate technology must be re-verified periodically or at least annually.

Section 12.11 What are the batch quality control requirements when conducting an initial drug test?

- (a) Each batch of specimens must contain the following calibrators and controls:
  - (1) At least one control certified to contain no drug or drug metabolite;
  - (2) At least one positive control with the drug or drug metabolite targeted at a concentration 25 percent above the cutoff;
  - (3) At least one control with the drug or drug metabolite targeted at a concentration 75 percent of the cutoff; and
  - (4) At least one control that appears as a donor specimen to the analysts.
- (b) Calibrators and controls must total at least 10 percent of the aliquots analyzed in each batch.

Section 12.12 What are the analytical and quality control requirements for conducting specimen validity tests?

- (a) Each specimen validity test result must be based on performing a single test on one aliquot;
- (b) The HHS-certified IITF must establish acceptance criteria and analyze calibrators and controls as appropriate to verify and document the validity of the test results in accordance with Section 12.14; and
- (c) Controls must be analyzed concurrently with specimens.

Section 12.13 What must an HHS-certified IITF do to validate a specimen validity test?

An HHS-certified IITF must demonstrate and document for each specimen validity test the appropriate performance characteristics of the test, and must re-verify the test periodically, or at least annually. Each new lot of reagent must be verified prior to being placed into service.

Section 12.14 What are the requirements for conducting each specimen validity test?

(a) The requirements for measuring creatinine concentration are as follows:

(1) The creatinine concentration must be measured to one decimal place on the test;

(2) The creatinine test must have the following calibrators and controls:

(i) A calibrator at 2 mg/dL;

(ii) A control in the range of 1.0 mg/dL to 1.5 mg/dL;

(iii) A control in the range of 3 mg/dL to 20 mg/dL; and

(iv) A control in the range of 21 mg/dL to 25 mg/dL.

(b) The requirements for measuring specific gravity are as follows:

(1) For specimens with creatinine test results greater than 5 mg/dL and less than 20 mg/dL, an IITF must perform a screening test using a refractometer to identify specific gravity values that are acceptable (equal to or greater than 1.003) or dilute (equal to or greater than 1.002 and less than 1.003). Specimens must be forwarded to an HHS-certified laboratory when the creatinine test result is less than or equal to 5 mg/dL or when the screening specific gravity test result is less than 1.002.

(2) The screening specific gravity test must have the following calibrators and controls:

(i) A calibrator or control at 1.000;

(ii) One control targeted at 1.002; and

(iii) One control in the range of 1.004 to 1.018.

(c) The requirements for measuring pH are as follows:

(1) The IITF may perform the pH test using a pH meter, colorimetric pH test, dipsticks, or pH paper. Specimens must be forwarded to an HHS-certified laboratory when the pH is less than 4.5 or equal to or greater than 9.0.

(2) The pH test must have, at a minimum, the following calibrators and controls:

(i) One control below 4.5;

(ii) One control between 4.5 and 9.0;

(iii) One control above 9.0; and

(iv) One or more calibrators as appropriate for the test. For a pH meter: calibrators at 4, 7, and 10.

(d) The requirements for measuring the nitrite concentration are that the nitrite test must have a calibrator at 200 mcg/mL nitrite, a control without nitrite (i.e., certified negative urine), one control in the range of 200 mcg/mL to 250 mcg/mL, and one control in the range of 500 mcg/mL to 625 mcg/mL. Specimens with a nitrite concentration equal to or greater than 200 mcg/mL must be forwarded to an HHS-certified laboratory; and,

(e) Requirements for performing oxidizing adulterant tests are that the test must include an appropriate calibrator at the cutoff specified in Sections 11.19(d)(3), (4), or (6) for the compound of interest, a control without the compound of interest (i.e., a certified negative control), and at least one control with one of the compounds of interest at a measurable concentration. Specimens with an oxidizing adulterant result equal to or greater than the cutoff must be forwarded to an HHS-certified laboratory.

Section 12.15 What are the requirements for an HHS-certified IITF to report a test result?

(a) An HHS-certified IITF must report a test result to the agency's MRO within an average of 3 working days after receipt of the specimen. Reports must use the Federal CCF and/or an electronic report. Before any test result can be reported, it must be certified by a certifying technician.

(b) A primary (A) specimen is reported negative when each drug test is negative and each specimen validity test result indicates that the specimen is a valid urine specimen.

(c) A primary (A) urine specimen is reported dilute when the creatinine concentration is greater than 5 mg/dL but less than 20 mg/dL and the specific gravity is equal to or greater than 1.002 but less than 1.003.

(d) An HHS-certified IITF shall reject a urine specimen for testing when a fatal flaw occurs as described in Section 15.1 or when a correctable flaw as described in Section 15.2 is not recovered. The HHS-certified IITF will indicate on the Federal CCF that the specimen was rejected for testing and provide the reason for reporting the rejected for testing result.

(e) An HHS-certified IITF must report results using the HHS-specified nomenclature published with the drug and biomarker testing panels.

(f) HHS-certified IITFs may transmit test results to the MRO by various electronic means (e.g., teleprinter, fax, or computer). Transmissions of the reports must ensure confidentiality and the results may not be reported verbally by telephone. IITFs and external service providers must ensure the confidentiality, integrity, and availability of the data and limit access to any data transmission, storage, and retrieval system.

(g) HHS-certified IITFs must fax, courier, mail, or electronically transmit a legible image or copy of the completed Federal CCF and/or forward a computer-generated electronic report. The computer-generated report must contain sufficient information to ensure that the test results can accurately represent the content of the custody and control form that the MRO received from the collector.

(h) For rejected specimens, IITFs must fax, courier, mail, or electronically transmit a legible image or copy of the completed Federal CCF.

Section 12.16 How does an HHS-certified IITF handle a specimen that tested positive, adulterated, substituted, or invalid at the IITF?

(a) The remaining specimen is resealed using a tamper-evident label/seal;

(b) The individual resealing the remaining specimen initials and dates the tamper-evident label/seal; and

(c) The resealed specimen and split specimen and the Federal CCF are sealed in a leak-proof plastic bag, and are sent to an HHS-certified laboratory under chain of custody within one

day after completing the drug and specimen validity tests.

Section 12.17 How long must an HHS-certified IITF retain a specimen?

A specimen that is negative, negative/dilute, or rejected for testing is discarded.

Section 12.18 How long must an HHS-certified IITF retain records?

(a) An HHS-certified IITF must retain all records generated to support test results for at least 2 years. The IITF may convert hardcopy records to electronic records for storage and then discard the hardcopy records after six months.

(b) A federal agency may request the HHS-certified IITF to maintain a documentation package (as described in Section 12.20) that supports the chain of custody, testing, and reporting of a donor's specimen that is under legal challenge by a donor. The federal agency's request to the IITF must be in writing and must specify the period of time to maintain the documentation package.

(c) An HHS-certified IITF may retain records other than those included in the documentation package beyond the normal two-year period of time.

Section 12.19 What statistical summary reports must an HHS-certified IITF provide?

(a) HHS-certified IITFs must provide to each federal agency for which they perform testing a semiannual statistical summary report that must be submitted by mail, fax, or email within 14 working days after the end of the semiannual period. The summary report must not include any personally identifiable information. A copy of the semiannual statistical summary report will also be sent to the Secretary or designated HHS representative. The semiannual statistical report contains the following information:

- (1) Reporting period (inclusive dates);
- (2) HHS-certified IITF name and address;

- (3) Federal agency name;
- (4) Total number of specimens tested;
- (5) Number of specimens collected by reason for test;
- (6) Number of specimens reported negative and the number reported negative/dilute;
- (7) Number of specimens rejected for testing because of a fatal flaw;
- (8) Number of specimens rejected for testing because of an uncorrected flaw;
- (9) Number of specimens tested positive by each initial drug test; and
- (10) Number of specimens forwarded to an HHS-certified laboratory for testing.

(b) An HHS-certified IITF must make copies of an agency's test results available when requested to do so by the Secretary or by the federal agency for which the IITF is performing drug-testing services.

(c) An HHS-certified IITF must ensure that a qualified individual is available to testify in a proceeding against a federal employee when the proceeding is based on a test result reported by the IITF.

#### Section 12.20 What HHS-certified IITF information is available to a federal agency?

(a) Following a federal agency's receipt of a positive, adulterated, or substituted drug test report from a laboratory, the federal agency may submit a written request for copies of the IITF records relating to the drug test results or a documentation package or any relevant certification, review, or revocation of certification records.

(b) Standard documentation packages provided by an HHS-certified IITF must contain the following items:

(1) A cover sheet providing a brief description of the procedures and tests performed on the donor's specimen;

(2) A table of contents that lists all documents and materials in the package by page number;

(3) A copy of the Federal CCF with any attachments, internal chain of custody records for the specimen, memoranda (if any) generated by the HHS-certified IITF, and a copy of the electronic report (if any) generated by the HHS-certified IITF;

(4) A brief description of the HHS-certified IITF's drug and specimen validity testing procedures, instrumentation, and batch quality control requirements;

(5) Copies of all test data for the donor's specimen with all calibrators and controls and copies of all internal chain of custody documents related to the tests; and

(6) Copies of the résumé or curriculum vitae for the RT and for the certifying technician of record.

#### Section 12.21 What HHS-certified IITF information is available to a federal employee?

A federal employee who is the subject of a drug test may provide a written request through the MRO and/or the federal agency requesting access to any records relating to the employee's drug test results or a documentation package (as described in Section 12.20) and any relevant certification, review, or revocation of certification records.

#### Section 12.22 What types of relationships are prohibited between an HHS-certified IITF and an MRO?

An HHS-certified IITF must not enter into any relationship with a federal agency's MRO that may be construed as a potential conflict of interest or derive any financial benefit by having a federal agency use a specific MRO.

This means an MRO may be an employee of the agency or a contractor for the agency; however, an MRO shall not be an employee or agent of or have any financial interest in the HHS-certified IITF for which the MRO is reviewing drug testing results. Additionally, an MRO shall not derive any financial benefit by having an agency use a specific HHS-certified IITF or have any agreement with an HHS-certified IITF that may be construed as a potential conflict of

interest.

Section 12.23 What type of relationship can exist between an HHS-certified IITF and an HHS-certified laboratory?

An HHS-certified IITF can enter into any relationship with an HHS-certified laboratory.

**Subpart M - Medical Review Officer (MRO)**

Section 13.1 Who may serve as an MRO?

- (a) A currently licensed physician who has:
  - (1) A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) degree;
  - (2) Knowledge regarding the pharmacology and toxicology of illicit drugs;
  - (3) The training necessary to serve as an MRO as set out in Section 13.3;
  - (4) Satisfactorily passed an initial examination administered by a nationally recognized entity or a subspecialty board that has been approved by the Secretary to certify MROs; and
  - (5) At least every five years from initial certification, completed requalification training on the topics in Section 13.3 and satisfactorily passed a requalification examination administered by a nationally recognized entity or a subspecialty board that has been approved by the Secretary to certify MROs.

Section 13.2 How are nationally recognized entities or subspecialty boards that certify MROs approved?

All nationally recognized entities or subspecialty boards which seek approval by the Secretary to certify physicians as MROs for federal workplace drug testing programs must submit their qualifications, a sample examination, and other necessary supporting examination materials (e.g., answers, previous examination statistics or other background examination

information, if requested). Approval will be based on an objective review of qualifications that include a copy of the MRO applicant application form, documentation that the continuing education courses are accredited by a professional organization, and the delivery method and content of the examination. Each approved MRO certification entity must resubmit their qualifications for approval every two years. The Secretary shall publish at least every two years a notification in the **Federal Register** listing those entities and subspecialty boards that have been approved. This notification is also available on the Internet at <http://www.samhsa.gov/workplace/drug-testing>.

### Section 13.3 What training is required before a physician may serve as an MRO?

- (a) A physician must receive training that includes a thorough review of the following:
  - (1) The collection procedures used to collect federal agency specimens;
  - (2) How to interpret test results reported by HHS-certified IITFs and laboratories (e.g., negative, negative/dilute, positive, adulterated, substituted, rejected for testing, and invalid);
  - (3) Chain of custody, reporting, and recordkeeping requirements for federal agency specimens;
  - (4) The HHS Mandatory Guidelines for Federal Workplace Drug Testing Programs for all authorized specimen types; and
  - (5) Procedures for interpretation, review (e.g., donor interview for legitimate medical explanations, review of documentation provided by the donor to support a legitimate medical explanation), and reporting of results specified by any federal agency for which the individual may serve as an MRO;
- (b) Certified MROs must complete training on any revisions to these Guidelines prior to their effective date, to continue serving as an MRO for federal agency specimens.

### Section 13.4 What are the responsibilities of an MRO?

(a) The MRO must review all positive, adulterated, rejected for testing, invalid, and substituted test results.

(b) Staff under the direct, personal supervision of the MRO may review and report negative and (for urine) negative/dilute test results to the agency's designated representative. The MRO must review at least 5 percent of all negative results reported by the MRO staff to ensure that the MRO staff are properly performing the review process.

(c) The MRO must discuss potential invalid results with the HHS-certified laboratory, as addressed in Section 11.19(g) to determine whether testing at another HHS-certified laboratory may be warranted.

(d) After receiving a report from an HHS-certified laboratory or (for urine) HHS-certified IITF, the MRO must:

(1) Review the information on the MRO copy of the Federal CCF that was received from the collector and the report received from the HHS-certified laboratory or HHS-certified IITF;

(2) Interview the donor when required;

(3) Make a determination regarding the test result; and

(4) Report the verified result to the federal agency.

(e) The MRO must maintain records for a minimum of two years while maintaining the confidentiality of the information. The MRO may convert hardcopy records to electronic records for storage and discard the hardcopy records after six months.

(f) The MRO must conduct a medical examination or a review of the examining physician's findings and make a determination of refusal to test or cancelled test when a collector reports that the donor was unable to provide a specimen, and an alternate specimen was not collected, as addressed in Sections 8.6 and 13.6.

### Section 13.5 What must an MRO do when reviewing a urine specimen's test results?

(a) When the HHS-certified laboratory or HHS-certified IITF reports a negative result for the primary (A) specimen, the MRO reports a negative result to the agency.

(b) When the HHS-certified laboratory or HHS-certified IITF reports a negative/dilute result for the primary (A) urine specimen, the MRO reports a negative/dilute result to the agency and directs the agency to immediately collect another specimen from the donor.

(1) If the recollected specimen provides a negative or negative/dilute result, the MRO reports a negative result to the agency, with no further action required.

(2) If the recollected specimen provides a result other than negative or negative/dilute, the MRO follows the procedures in 13.5(c) through (f) for the recollected specimen.

(c) When the HHS-certified laboratory reports multiple results for the primary (A) urine specimen, as the MRO, you must follow the verification procedures described in 13.5(d) through (f) and:

(1) Report all verified positive and/or refusal to test results to the federal agency.

(2) If an invalid result was reported in conjunction with a positive, adulterated, or substituted result, do not report the verified invalid result to the federal agency at this time. The MRO takes the action described in 13.5(f) for the verified invalid result(s) for the primary (A) specimen only when:

(i) The MRO verifies the laboratory-reported positive, adulterated, or substituted result as negative based on a legitimate medical explanation as described in 13.5(d)(2) and 13.5(e)(1); or

(ii) The split (B) specimen is tested and reported as a failure to reconfirm as described in Section 14.6(m).

(d) When the HHS-certified laboratory reports a positive result for the primary (A) specimen, the MRO must contact the donor to determine if there is any legitimate medical explanation for the positive result.

(1) If the donor admits unauthorized use of the drug(s) that caused the positive result, the MRO reports the test result as positive to the agency. The MRO must document the donor's admission of unauthorized drug use in the MRO records and in the report to the agency.

(2) If the donor provides documentation (e.g., a valid prescription) to support a legitimate medical explanation for the positive result, the MRO reports the test result as negative to the agency. If the laboratory also reports that the urine specimen is dilute, the MRO reports a negative/dilute result to the agency and directs the agency to immediately collect another specimen from the donor. The MRO follows the procedures in 13.5(b)(1) or (2) for the recollected specimen.

(i) Passive exposure to a drug (e.g., exposure to secondhand marijuana smoke) is not a legitimate medical explanation for a positive drug test result.

(ii) Ingestion of food products containing a drug (e.g., products containing marijuana, poppy seeds containing codeine and/or morphine) is not a legitimate medical explanation for a positive urine drug test result.

(iii) A physician's authorization or medical recommendation for a Schedule 1 controlled substance is not a legitimate medical explanation for a positive drug test result.

(3) If the donor is unable to provide a legitimate medical explanation for the positive result, the MRO reports the positive result to the agency. If the laboratory also reports that the urine specimen is dilute, the MRO may choose not to report the dilute result.

(e) When the HHS-certified laboratory reports an adulterated or substituted result for the primary (A) urine specimen, the MRO contacts the donor to determine if the donor has a legitimate medical explanation for the adulterated or substituted result.

(1) If the donor provides a legitimate medical explanation, the MRO reports a negative result to the federal agency.

(2) If the donor is unable to provide a legitimate explanation, the MRO reports a refusal to test to the federal agency because the urine specimen was adulterated or substituted.

(f) When the HHS-certified laboratory reports an invalid result for the primary (A) urine specimen, the MRO must contact the donor to determine if there is a legitimate explanation for the invalid result. In the case of an invalid result based on pH of 9.0 to 9.5, when an employee has no other medical explanation for the pH in this range, the MRO must consider whether there is evidence of elapsed time and high temperature that could account for the pH value. The MRO may contact the collection site, HHS-certified IITF, and/or HHS-certified laboratory to discuss time and temperature issues (e.g., time elapsed from collection to receipt at the testing facility, likely temperature conditions between the time of the collection and transportation to the testing facility, specimen storage conditions).

(1) If the donor provides a legitimate explanation (e.g., a prescription medication) or if the MRO determines that time and temperature account for the pH in the 9.0 to 9.5 range, the MRO reports a test cancelled result with the reason for the invalid result and informs the federal agency that a recollection is not required because there is a legitimate explanation for the invalid result.

(2) If the donor is unable to provide a legitimate explanation or if the MRO determines that time and temperature fail to account for the pH in the 9.0 - 9.5 range, the MRO reports a test cancelled result with the reason for the invalid result and directs the federal agency to immediately collect another urine specimen from the donor using a direct observed collection.

(i) If the specimen collected under direct observation provides a valid result, the MRO follows the procedures in 13.5(a) through (e).

(ii) If the specimen collected under direct observation provides an invalid result, the MRO reports this specimen as test cancelled and recommends that the agency collect another authorized specimen type (e.g., oral fluid).

(g) When two separate specimens collected during the same testing event were sent to the HHS-certified laboratory for testing (e.g., the collector sent a urine specimen out of temperature range and the subsequently collected specimen -- urine or another authorized specimen type), as

the MRO, you must follow the verification procedures described in Sections 13.4, 13.5, and 13.6, and:

(1) If both specimens were verified negative, report the result as negative.

(2) If one specimen was verified negative and the other was not (i.e., the specimen was verified as negative/dilute or as positive, adulterated, substituted, and/or invalid), report only the verified result(s) other than negative. For example, if you verified one specimen as negative and the other as a refusal to test because the specimen was substituted, report only the refusal to the federal agency.

(3) If both specimens were verified as positive, adulterated, and/or substituted, report all results. For example, if you verified one specimen as positive and the other as a refusal to test because the specimen was adulterated, report the positive and the refusal results to the federal agency.

(4) If one specimen has been verified and the HHS-certified laboratory has not reported the result(s) of the other specimen,

(i) Report verified result(s) of positive, adulterated, or substituted immediately and do not wait to receive the result(s) of the other specimen.

(ii) Do not report a verified result of negative, negative/dilute, or invalid for the first specimen to the federal agency. Hold the report until results of both specimens have been received and verified.

(5) When the HHS-certified laboratory reports an invalid result for one or both specimens, follow the procedures in paragraph (c) above.

(h) When the HHS-certified laboratory or HHS-certified IITF reports a rejected for testing result for the primary (A) specimen, the MRO reports a test cancelled result to the agency and recommends that the agency collect another specimen from the donor. The recollected specimen must be the same type (i.e., urine).

Section 13.6 What action does the MRO take when the collector reports that the donor did not provide a sufficient amount of urine for a drug test?

(a) When another specimen type (e.g., oral fluid) was collected as authorized by the federal agency, the MRO reviews and reports the test result in accordance with the Mandatory Guidelines for Federal Workplace Drug Testing Programs using the alternative specimen.

(b) When the federal agency did not authorize the collection of an alternative specimen, the MRO consults with the federal agency. The federal agency immediately directs the donor to obtain, within five days, an evaluation from a licensed physician, acceptable to the MRO, who has expertise in the medical issues raised by the donor's failure to provide a specimen. The MRO may perform this evaluation if the MRO has appropriate expertise.

(1) For purposes of this section, a medical condition includes an ascertainable physiological condition (e.g., a urinary system dysfunction) or a medically documented pre-existing psychological disorder, but does not include unsupported assertions of "situational anxiety" or dehydration. Permanent or long-term medical conditions are those physiological, anatomic, or psychological abnormalities documented as being present prior to the attempted collection, and considered not amenable to correction or cure for an extended period of time. Examples would include destruction (any cause) of the glomerular filtration system leading to renal failure; unrepaired traumatic disruption of the urinary tract; or a severe psychiatric disorder focused on genitourinary matters. Acute or temporary medical conditions, such as cystitis, urethritis, or prostatitis, though they might interfere with collection for a limited period of time, cannot receive the same exceptional consideration as the permanent or long-term conditions discussed in the previous sentence.

(2) As the MRO, if another physician will perform the evaluation, you must provide the other physician with the following information and instructions:

(i) That the donor was required to take a federally regulated drug test, but was unable to provide a sufficient amount of urine to complete the test;

(ii) The consequences of the appropriate federal agency regulation for refusing to take the required drug test;

(iii) That, after completing the evaluation, the referral physician must agree to provide a written statement to the MRO with a recommendation for one of the determinations described in paragraph (b)(3) of this section and the basis for the recommendation. The statement must not include detailed information on the employee's medical condition beyond what is necessary to explain the referral physician's conclusion.

(3) As the MRO, if another physician performed the evaluation, you must consider and assess the referral physician's recommendations in making your determination. You must make one of the following determinations and report it to the federal agency in writing:

(i) A medical condition as defined in paragraph (b)(1) of this section has, or with a high degree of probability could have, precluded the employee from providing a sufficient amount of urine, but is not a permanent or long-term disability. As the MRO, you must report a test cancelled result to the federal agency.

(ii) A permanent or long-term medical condition as defined in paragraph (b)(1) of this section has, or with a high degree of probability could have, precluded the employee from providing a sufficient amount of urine and is highly likely to prevent the employee from providing a sufficient amount of urine for a very long or indefinite period of time. As the MRO, you must follow the requirements of Section 13.7, as appropriate. If Section 13.7 is not applicable, you report a test cancelled result to the federal agency and recommend that the agency authorize collection of an alternative specimen type (e.g., oral fluid) for any subsequent drug tests for the donor.

(iii) There is not an adequate basis for determining that a medical condition has, or with a high degree of probability could have, precluded the employee from providing a sufficient amount of urine. As the MRO, you must report a refusal to test to the federal agency.

(4) When a federal agency receives a report from the MRO indicating that a test is cancelled as provided in paragraph (b)(3)(i) of this section, the agency takes no further action with respect to the donor. When a test is canceled as provided in paragraph (b)(3)(ii) of this section, the agency takes no further action with respect to the donor other than designating collection of an alternate specimen type (i.e., authorized by the Mandatory Guidelines for Federal Workplace Drug Testing Programs) for any subsequent collections, in accordance with the federal agency plan. The donor remains in the random testing pool.

13.7 What happens when an individual is unable to provide a sufficient amount of urine for a federal agency applicant/pre-employment test, a follow-up test, or a return-to-duty test because of a permanent or long-term medical condition?

(a) This section concerns a situation in which the donor has a medical condition that precludes the donor from providing a sufficient specimen for a federal agency applicant/pre-employment test, a follow-up test, or a return-to-duty test and the condition involves a permanent or long-term disability and the federal agency does not authorize collection of an alternative specimen. As the MRO in this situation, you must do the following:

(1) You must determine if there is clinical evidence that the individual is an illicit drug user. You must make this determination by personally conducting, or causing to be conducted, a medical evaluation and through consultation with the donor's physician and/or the physician who conducted the evaluation under Section 13.6.

(2) If you do not personally conduct the medical evaluation, you must ensure that one is conducted by a licensed physician acceptable to you.

(b) If the medical evaluation reveals no clinical evidence of illicit drug use, as the MRO, you must report the result to the federal agency as a negative test with written notations regarding results of both the evaluation conducted under Section 13.6 and any further medical examination. This report must state the basis for the determination that a permanent or long-term

medical condition exists, making provision of a sufficient urine specimen impossible, and for the determination that no signs and symptoms of drug use exist. The MRO recommends that the agency authorize collection of an alternate specimen type (e.g., oral fluid) for any subsequent collections.

(c) If the medical evaluation reveals clinical evidence of drug use, as the MRO, you must report the result to the federal agency as a cancelled test with written notations regarding results of both the evaluation conducted under Section 13.6 and any further medical examination. This report must state that a permanent or long-term medical condition (as defined in Section 13.6(b)(1)) exists, making provision of a sufficient urine specimen impossible, and state the reason for the determination that signs and symptoms of drug use exist. Because this is a cancelled test, it does not serve the purposes of a negative test (e.g., the federal agency is not authorized to allow the donor to begin or resume performing official functions, because a negative test is needed for that purpose).

#### Section 13.8 Who may request a test of a split (B) specimen?

(a) For a positive, adulterated, or substituted result reported on a primary (A) specimen, a donor may request through the MRO that the split (B) specimen be tested by a second HHS-certified laboratory to verify the result reported by the first HHS-certified laboratory.

(b) The donor has 72 hours (from the time the MRO notified the donor that the donor's specimen was reported positive, adulterated, or substituted to request a test of the split (B) specimen. The MRO must inform the donor that the donor has the opportunity to request a test of the split (B) specimen when the MRO informs the donor that a positive, adulterated, or substituted result is being reported to the federal agency on the primary (A) specimen.

#### Section 13.9 How does an MRO report a primary (A) specimen test result to an agency?

(a) The MRO must report all verified results to an agency using the completed MRO

copy of the Federal CCF or a separate report using a letter/memorandum format. The MRO may use various electronic means for reporting (e.g., teleprinter, fax, or computer). Transmissions of the reports must ensure confidentiality. The MRO and external service providers must ensure the confidentiality, integrity, and availability of the data and limit access to any data transmission, storage, and retrieval system.

(b) A verified result may not be reported to the agency until the MRO has completed the review process.

(c) The MRO must send a copy of either the completed MRO copy of the Federal CCF or the separate letter/memorandum report for all positive, adulterated, and substituted results.

(d) The MRO must not disclose numerical values of drug test results to the agency.

(e) The MRO must report drug test results using the HHS-specified nomenclature published with the drug and biomarker testing panels.

#### Section 13.10 What types of relationships are prohibited between an MRO and an HHS-certified laboratory or an HHS-certified IITF?

An MRO must not be an employee, agent of, or have any financial interest in an HHS-certified laboratory or an HHS-certified IITF for which the MRO is reviewing drug test results.

This means an MRO must not derive any financial benefit by having an agency use a specific HHS-certified laboratory or HHS-certified IITF, or have any agreement with the HHS-certified laboratory or the HHS-certified IITF that may be construed as a potential conflict of interest.

#### Section 13.11 What reports must an MRO provide to the Secretary for urine testing?

(a) An MRO must send to the Secretary or designated HHS representative a semiannual report of federal agency specimens that were reported as positive for a drug or drug metabolite by a laboratory and verified as negative by the MRO. The report must not include any

personally identifiable information for the donor and must be submitted by mail, fax, or other secure electronic transmission method within 14 working days after the end of the semiannual period (i.e., in January and July). The semiannual report must contain the following information:

- (1) Reporting period (inclusive dates);
- (2) MRO name, company name, and address;
- (3) Federal agency name; and
- (4) For each laboratory-reported positive drug test result that was verified as negative by the MRO:

- (i) Specimen identification number;
  - (ii) Laboratory name and address;
  - (iii) Positive drug(s) or drug metabolite(s) the MRO verified as negative;
  - (iv) MRO reason for verifying the positive drug(s) or drug metabolite(s) as negative (e.g., a donor prescription [the MRO must specify the prescribed drug]);
  - (v) All results reported to the federal agency by the MRO for the specimen; and
  - (vi) Date of the MRO report to the federal agency.
- (b) An MRO must provide copies of the drug test reports that the MRO has sent to a federal agency when requested to do so by the Secretary.
- (c) If an MRO did not verify any positive laboratory results as negative during the reporting period, the MRO should file a report that states that the MRO has no reportable results during the applicable reporting period.

#### Section 13.12 What are a federal agency's responsibilities for designating an MRO?

(a) Before allowing an individual to serve as an MRO for the agency, a federal agency must verify and document the following:

- (1) that the individual satisfies all requirements in Section 13.1, including certification by an MRO certification organization that has been approved by the Secretary, as described in

Section 13.2; and

(2) that the individual is not an employee, agent of, or have any financial interest in an HHS-certified laboratory or an HHS-certified IITF that tests the agency's specimens, as described in Section 13.10.

(b) The federal agency must verify and document that each MRO reviewing and reporting results for the agency:

(1) completes training on any revisions to these Guidelines prior to their effective date;

(2) at least every five years, maintains their certification by completing requalification training and passing a requalification examination; and

(3) provides biannual reports to the Secretary or designated HHS representative as required in Section 13.11;

(c) The federal agency must ensure that each MRO reports drug test results to the agency in accordance with Sections 13.9 and 14.7.

(1) Before allowing an MRO to report results electronically, the agency must obtain documentation from the MRO to confirm that the MRO and any external service providers ensure the confidentiality, integrity, and availability of the data and limit access to any data transmission, storage, and retrieval system.

## **Subpart N - Split Specimen Tests**

### Section 14.1 When may a split (B) specimen be tested?

(a) The donor may request, verbally or in writing, through the MRO that the split (B) specimen be tested at a different (i.e., second) HHS-certified laboratory when the primary (A) specimen was determined by the MRO to be positive, adulterated, or substituted.

(b) A donor has 72 hours to initiate the request after being informed of the result by the MRO. The MRO must document in the MRO's records the verbal request from the donor to

have the split (B) specimen tested.

(c) If a split (B) urine specimen cannot be tested by a second HHS-certified laboratory (e.g., insufficient specimen, lost in transit, split not available, no second HHS-certified laboratory available to perform the test), the MRO reports to the federal agency that the test must be cancelled and the reason for the cancellation. The MRO directs the federal agency to ensure the immediate recollection of another urine specimen from the donor under direct observation, with no notice given to the donor of this collection requirement until immediately before the collection.

(d) If a donor chooses not to have the split (B) specimen tested by a second HHS-certified laboratory, a federal agency may have a split (B) specimen retested as part of a legal or administrative proceeding to defend an original positive, adulterated, or substituted result.

Section 14.2 How does an HHS-certified laboratory test a split (B) specimen when the primary (A) specimen was reported positive?

(a) The testing of a split (B) specimen for a drug or metabolite is not subject to the testing cutoffs established.

(b) The HHS-certified laboratory is only required to confirm the presence of the drug or metabolite that was reported positive in the primary (A) specimen.

(c) For a split (B) urine specimen, if the second HHS-certified laboratory fails to reconfirm the presence of the drug or drug metabolite that was reported by the first HHS-certified laboratory, the second laboratory must conduct specimen validity tests in an attempt to determine the reason for being unable to reconfirm the presence of the drug or drug metabolite. The second laboratory should conduct the same specimen validity tests as it would conduct on a primary (A) urine specimen and reports those results to the MRO.

Section 14.3 How does an HHS-certified laboratory test a split (B) urine specimen when the

primary (A) specimen was reported adulterated?

(a) An HHS-certified laboratory must use one of the following criteria to reconfirm an adulterated result when testing a split (B) urine specimen:

(1) pH must be measured using the laboratory's confirmatory pH test with the appropriate cutoff (i.e., either less than 4 or equal to or greater than 11);

(2) Nitrite must be measured using the laboratory's confirmatory nitrite test with a cutoff of equal to or greater than 500 mcg/mL;

(3) Surfactant must be measured using the laboratory's confirmatory surfactant test with a cutoff of equal to or greater than 100 mcg/mL dodecylbenzene sulfonate-equivalent cutoff; or

(4) For adulterants without a specified cutoff (e.g., glutaraldehyde, chromium (VI), pyridine, halogens (such as, chlorine from bleach, iodine), peroxidase, peroxide, other oxidizing agents), the laboratory must use its confirmatory specimen validity test at an established LOQ to reconfirm the presence of the adulterant.

(b) The second HHS-certified laboratory may only conduct the confirmatory specimen validity test(s) needed to reconfirm the adulterated result reported by the first HHS-certified laboratory.

Section 14.4 How does an HHS-certified laboratory test a split (B) urine specimen when the primary (A) specimen was reported substituted?

(a) An HHS-certified laboratory must use the following criteria to reconfirm a substituted result when testing a split (B) urine specimen:

(1) For substitution based on creatinine and specific gravity testing: The creatinine must be measured using the laboratory's confirmatory creatinine test with a cutoff of less than 2 mg/dL, and the specific gravity must be measured using the laboratory's confirmatory specific gravity test with the specified cutoffs of less than or equal to 1.0010 or equal to or greater than 1.0200.

(2) For substitution based on biomarker testing: The laboratory must test for the biomarker using its confirmatory test (i.e., using the confirmatory test analytes and cutoffs in the biomarker testing panel).

(b) The second HHS-certified laboratory may only conduct the confirmatory specimen validity test(s) needed to reconfirm the substituted result reported by the first HHS-certified laboratory.

#### Section 14.5 Who receives the split (B) specimen result?

The second HHS-certified laboratory must report the result to the MRO using the HHS-specified nomenclature published with the drug and biomarker testing panels.

#### Section 14.6 What action(s) does an MRO take after receiving the split (B) urine specimen result from the second HHS-certified laboratory?

The MRO takes the following actions when the second HHS-certified laboratory reports the result for the split (B) urine specimen as:

(a) Reconfirmed the drug(s), adulteration, and/or substitution result. The MRO reports reconfirmed to the agency.

(b) Failed to reconfirm a single or all drug positive results and the specimen was adulterated. If the donor provides a legitimate medical explanation for the adulteration result, the MRO reports a failed to reconfirm result (specifying the drug[s]) and cancels both tests. If there is no legitimate medical explanation, the MRO reports a failed to reconfirm result (specifying the drug[s]) and a refusal to test to the agency and indicates the adulterant that is present in the specimen. The MRO gives the donor 72 hours to request that Laboratory A retest the primary (A) specimen for the adulterant. If Laboratory A reconfirms the adulterant, the MRO reports refusal to test and indicates the adulterant present. If Laboratory A fails to reconfirm the adulterant, the MRO cancels both tests and directs the agency to immediately collect another

specimen using a direct observed collection procedure. The MRO shall notify the appropriate regulatory office about the failed to reconfirm and cancelled test.

(c) Failed to reconfirm a single or all drug positive results and the specimen was substituted. If the donor provides a legitimate medical explanation for the substituted result, the MRO reports a failed to reconfirm result (specifying the drug[s]) and cancels both tests. If there is no legitimate medical explanation, the MRO reports a failed to reconfirm result (specifying the drug[s]) and a refusal to test (substituted) to the agency. The MRO gives the donor 72 hours to request additional review or testing as follows:

(1) For substitution based on creatinine and specific gravity: request that Laboratory A review the creatinine and specific gravity results for the primary (A) specimen.

(2) For substitution based on biomarker testing: request that Laboratory A test the primary (A) specimen using its confirmatory test for the biomarker.

(i) If the primary (A) specimen's test results confirm that the specimen was substituted, the MRO reports a refusal to test (substituted) to the agency.

(ii) If the primary (A) specimen's results fail to confirm that the specimen was substituted, the MRO cancels both tests and directs the agency to immediately collect another specimen using a direct observed collection procedure. The MRO shall notify the HHS office responsible for coordination of the drug-free workplace program about the failed to reconfirm and cancelled test.

(d) Failed to reconfirm a single or all drug positive results and the specimen was not adulterated or substituted. The MRO reports to the agency a failed to reconfirm result (specifying the drug[s]), cancels both tests, and notifies the HHS office responsible for coordination of the drug-free workplace program.

(e) Failed to reconfirm a single or all drug positive results and the specimen had an invalid result. The MRO reports to the agency a failed to reconfirm result (specifying the drug[s] and the reason for the invalid result), cancels both tests, directs the agency to immediately collect

another specimen using a direct observed collection procedure, and notifies the HHS office responsible for coordination of the drug-free workplace program.

(f) Failed to reconfirm one or more drugs, reconfirmed one or more drugs, and the specimen was adulterated. The MRO reports to the agency a reconfirmed result (specifying the drug[s]) and a failed to reconfirm result (specifying the drug[s]). The MRO tells the agency that it may take action based on the reconfirmed drug(s) although Laboratory B failed to reconfirm one or more drugs and found that the specimen was adulterated. The MRO shall notify the HHS office responsible for coordination of the drug-free workplace program regarding the test results for the specimen.

(g) Failed to reconfirm one or more drugs, reconfirmed one or more drugs, and the specimen was substituted. The MRO reports to the agency a reconfirmed result (specifying the drug[s]) and a failed to reconfirm result (specifying the drug[s]). The MRO tells the agency that it may take action based on the reconfirmed drug(s) although Laboratory B failed to reconfirm one or more drugs and found that the specimen was substituted. The MRO shall notify the HHS office responsible for coordination of the drug-free workplace program regarding the test results for the specimen.

(h) Failed to reconfirm one or more drugs, reconfirmed one or more drugs, and the specimen was not adulterated or substituted. The MRO reports to the agency a reconfirmed result (specifying the drug[s]) and a failed to reconfirm result (specifying the drug[s]). The MRO tells the agency that it may take action based on the reconfirmed drug(s) although Laboratory B failed to reconfirm one or more drugs. The MRO shall notify the HHS office responsible for coordination of the drug-free workplace program regarding the test results for the specimen.

(i) Failed to reconfirm one or more drugs, reconfirmed one or more drugs, and the specimen had an invalid result. The MRO reports to the agency a reconfirmed result (specifying the drug[s]) and a failed to reconfirm result (specifying the drug[s]). The MRO tells the agency

that it may take action based on the reconfirmed drug(s) although Laboratory B failed to reconfirm one or more drugs and reported an invalid result. The MRO shall notify the HHS office responsible for coordination of the drug-free workplace program regarding the test results for the specimen.

(j) Failed to reconfirm substitution or adulteration. The MRO reports to the agency a failed to reconfirm result (not adulterated: specifying the adulterant/pH or not substituted) and cancels both tests. The MRO shall notify the HHS office responsible for coordination of the drug-free workplace program regarding the test results for the specimen.

(k) Failed to reconfirm substitution or adulteration and the specimen had an invalid result. The MRO reports to the agency a failed to reconfirm result (not adulterated: specifying the adulterant/pH or not substituted, and the reason for the invalid result), cancels both tests, directs the agency to immediately collect another specimen using a direct observed collection procedure and notifies the HHS office responsible for coordination of the drug-free workplace program.

(l) Failed to reconfirm a single or all drug positive results and reconfirmed an adulterated or substituted result. The MRO reports to the agency a reconfirmed result (adulterated or substituted) and a failed to reconfirm result (specifying the drug[s]). The MRO tells the agency that it may take action based on the reconfirmed result (adulterated or substituted) although Laboratory B failed to reconfirm the drug(s) result.

(m) Failed to reconfirm a single or all drug positive results and failed to reconfirm the adulterated or substituted result. The MRO reports to the agency a failed to reconfirm result (specifying the drug[s] and not adulterated: specifying the adulterant/pH or not substituted) and cancels both tests. The MRO shall notify the HHS office responsible for coordination of the drug-free workplace program regarding the test results for the specimen.

(n) Failed to reconfirm at least one drug and reconfirmed the adulterated result. The MRO reports to the agency a reconfirmed result (specifying the drug[s] and adulterated) and a failed to reconfirm result (specifying the drug[s]). The MRO tells the agency that it may take

action based on the reconfirmed drug(s) and the adulterated result although Laboratory B failed to reconfirm one or more drugs.

(o) Failed to reconfirm at least one drug and failed to reconfirm the adulterated result.

The MRO reports to the agency a reconfirmed result (specifying the drug[s]) and a failed to reconfirm result (specifying the drug[s] and not adulterated: specifying the adulterant/pH). The MRO tells the agency that it may take action based on the reconfirmed drug(s) although Laboratory B failed to reconfirm one or more drugs and failed to reconfirm the adulterated result.

(p) Failed to reconfirm an adulterated result and failed to reconfirm a substituted result.

The MRO reports to the agency a failed to reconfirm result (not adulterated: specifying the adulterant/pH, and not substituted) and cancels both tests. The MRO shall notify the HHS office responsible for coordination of the drug-free workplace program regarding the test results for the specimen.

(q) Failed to reconfirm an adulterated result and reconfirmed a substituted result. The MRO reports to the agency a reconfirmed result (substituted) and a failed to reconfirm result (not adulterated: specifying the adulterant/pH). The MRO tells the agency that it may take action based on the substituted result although Laboratory B failed to reconfirm the adulterated result.

(r) Failed to reconfirm a substituted result and reconfirmed an adulterated result. The MRO reports to the agency a reconfirmed result (adulterated) and a failed to reconfirm result (not substituted). The MRO tells the agency that it may take action based on the adulterated result although Laboratory B failed to reconfirm the substituted result.

#### Section 14.7 How does an MRO report a split (B) specimen test result to an agency?

(a) The MRO must report all verified results to an agency using the completed MRO copy of the Federal CCF or a separate report using a letter/memorandum format. The MRO may use various electronic means for reporting (e.g., teleprinter, fax, or computer). Transmissions of the reports must ensure confidentiality. The MRO and external service providers must ensure

the confidentiality, integrity, and availability of the data and limit access to any data transmission, storage, and retrieval system.

(b) A verified result may not be reported to the agency until the MRO has completed the review process.

(c) The MRO must send a copy of either the completed MRO copy of the Federal CCF or the separate letter/memorandum report for all split specimen results.

(d) The MRO must not disclose the numerical values of the drug test results to the agency.

(e) The MRO must report drug test results using the HHS-specified nomenclature published with the drug and biomarker testing panels.

#### Section 14.8 How long must an HHS-certified laboratory retain a split (B) specimen?

A split (B) specimen is retained for the same period of time that a primary (A) specimen is retained and under the same storage conditions. This applies even for those cases when the split (B) specimen is tested by a second HHS-certified laboratory and the second HHS-certified laboratory does not confirm the original result reported by the first HHS-certified laboratory for the primary (A) specimen.

### **Subpart O - Criteria for Rejecting a Specimen for Testing**

#### Section 15.1 What discrepancies require an HHS-certified laboratory or an HHS-certified IITF to report a urine specimen as rejected for testing?

The following discrepancies are considered to be fatal flaws. The HHS-certified laboratory or IITF must stop the testing process, reject the specimen for testing, and indicate the reason for rejecting the specimen on the Federal CCF when:

(a) The specimen ID number on the primary (A) or split (B) specimen label/seal does not

match the ID number on the Federal CCF, or the ID number is missing either on the Federal CCF or on either specimen label/seal;

(b) The primary (A) specimen label/seal is missing, misapplied, broken, or shows evidence of tampering and the split (B) specimen cannot be re-designated as the primary (A) specimen;

(c) The collector's printed name and signature are omitted on the Federal CCF;

(d) There is an insufficient amount of specimen for analysis in the primary (A) specimen unless the split (B) specimen can be re-designated as the primary (A) specimen;

(e) The accessions failed to document the primary (A) specimen seal condition on the Federal CCF at the time of accessioning, and the split (B) specimen cannot be re-designated as the primary (A) specimen;

(f) The specimen was received at the HHS-certified laboratory or IITF without a CCF;

(g) The CCF was received at the HHS-certified laboratory or IITF without a specimen;

(h) The collector performed two separate collections using one CCF; or

(i) The HHS-certified laboratory or IITF identifies a flaw (other than those specified above) that prevents testing or affects the forensic defensibility of the drug test and cannot be corrected.

Section 15.2 What discrepancies require an HHS-certified laboratory or an HHS-certified IITF to report a specimen as rejected for testing unless the discrepancy is corrected?

The following discrepancies are considered to be correctable:

(a) If a collector failed to sign the Federal CCF, the HHS-certified laboratory or IITF must attempt to recover the collector's signature before reporting the test result. If the collector can provide a memorandum for record recovering the signature, the HHS-certified laboratory or IITF may report the test result for the specimen. If, after holding the specimen for at least 5 business days, the HHS-certified laboratory or IITF cannot recover the collector's signature, the

laboratory or IITF must report a rejected for testing result and indicate the reason for the rejected for testing result on the Federal CCF.

(b) If a specimen is submitted using a non-federal form or an expired Federal CCF, the HHS-certified laboratory or IITF must test the specimen and also attempt to obtain a memorandum for record explaining why a non-federal form or an expired Federal CCF was used and ensure that the form used contains all the required information. If, after holding the specimen for at least 5 business days, the HHS-certified laboratory or IITF cannot obtain a memorandum for record from the collector, the laboratory or IITF must report a rejected for testing result and indicate the reason for the rejected for testing result on the report to the MRO.

Section 15.3 What discrepancies are not sufficient to require an HHS-certified laboratory or an HHS-certified IITF to reject a urine specimen for testing or an MRO to cancel a test?

(a) The following omissions and discrepancies on the Federal CCF that are received by the HHS-certified laboratory or IITF should not cause an HHS-certified laboratory or IITF to reject a urine specimen or cause an MRO to cancel a test:

- (1) An incorrect laboratory name and address appearing at the top of the form;
- (2) Incomplete/incorrect/unreadable employer name or address;
- (3) MRO name is missing;
- (4) Incomplete/incorrect MRO address;
- (5) A transposition of numbers in the donor's Social Security Number or employee identification number;
- (6) A telephone number is missing/incorrect;
- (7) A fax number is missing/incorrect;
- (8) A "reason for test" box is not marked;
- (9) A "drug tests to be performed" box is not marked;
- (10) A "collection" box is not marked;

- (11) The “observed” box is not marked (if applicable);
- (12) The collection site address is missing;
- (13) The collector’s printed name is missing but the collector’s signature is properly recorded;
- (14) The time of collection is not indicated;
- (15) The date of collection is not indicated;
- (16) Incorrect name of delivery service;
- (17) The collector has changed or corrected information by crossing out the original information on either the Federal CCF or specimen label/seal without dating and initialing the change; or
- (18) The donor’s name inadvertently appears on the HHS-certified laboratory or IITF copy of the Federal CCF or on the tamper-evident labels used to seal the specimens.
- (19) The collector failed to check the specimen temperature box and the “Remarks” line did not have a comment regarding the temperature being out of range. If, after at least 5 business days, the collector cannot provide a memorandum for record to attest to the fact that the collector did measure the specimen temperature, the HHS-certified laboratory or IITF may report the test result for the specimen but indicates that the collector could not provide a memorandum to recover the omission.

(b) The following omissions and discrepancies on the Federal CCF that are made at the HHS-certified laboratory or IITF should not cause an MRO to cancel a test:

- (1) The testing laboratory or IITF fails to indicate the correct name and address in the results section when a different laboratory or IITF name and address is printed at the top of the Federal CCF;
- (2) The accessioner fails to print their name;
- (3) The certifying scientist or certifying technician fails to print their name;
- (4) The certifying scientist or certifying technician accidentally initials the Federal CCF

rather than signing for a specimen reported as rejected for testing;

(c) The above omissions and discrepancies should occur no more than once a month. The expectation is that each trained collector and HHS-certified laboratory or IITF will make every effort to ensure that the Federal CCF is properly completed and that all the information is correct. When an error occurs more than once a month, the MRO must direct the collector, HHS-certified laboratory, or HHS-certified IITF (whichever is responsible for the error) to immediately take corrective action to prevent the recurrence of the error.

#### Section 15.4 What discrepancies may require an MRO to cancel a test?

(a) An MRO must attempt to correct the following errors:

(1) The donor's signature is missing on the MRO copy of the Federal CCF and the collector failed to provide a comment that the donor refused to sign the form;

(2) The certifying scientist failed to sign the Federal CCF for a specimen being reported drug positive, adulterated, invalid, or substituted; or

(3) The electronic report provided by the HHS-certified laboratory or HHS-certified IITF does not contain all the data elements required for the HHS standard laboratory or IITF electronic report for a specimen being reported drug positive, adulterated, invalid result, or substituted.

(b) If error (a)(1) occurs, the MRO must contact the collector to obtain a statement to verify that the donor refused to sign the MRO copy. If, after at least 5 business days, the collector cannot provide such a statement, the MRO must cancel the test.

(c) If error (a)(2) occurs, the MRO must obtain a statement from the certifying scientist that they inadvertently forgot to sign the Federal CCF, but did, in fact, properly conduct the certification review. If, after at least 5 business days, the MRO cannot get a statement from the certifying scientist, the MRO must cancel the test.

(d) If error (a)(3) occurs, the MRO must contact the HHS-certified laboratory or HHS-

certified IITF. If, after at least 5 business days, the laboratory or IITF does not retransmit a corrected electronic report, the MRO must cancel the test.

## **Subpart P - Laboratory or IITF Suspension/Revocation Procedures**

### Section 16.1 When may the HHS certification of a laboratory or IITF be suspended?

These procedures apply when:

(a) The Secretary has notified an HHS-certified laboratory or IITF in writing that its certification to perform drug testing under these Guidelines has been suspended or that the Secretary proposes to revoke such certification.

(b) The HHS-certified laboratory or IITF has, within 30 days of the date of such notification or within 3 days of the date of such notification when seeking an expedited review of a suspension, requested in writing an opportunity for an informal review of the suspension or proposed revocation.

### Section 16.2 What definitions are used for this subpart?

Appellant. Means the HHS-certified laboratory or IITF which has been notified of its suspension or proposed revocation of its certification to perform testing and has requested an informal review thereof.

Respondent. Means the person or persons designated by the Secretary in implementing these Guidelines.

Reviewing Official. Means the person or persons designated by the Secretary who will review the suspension or proposed revocation. The reviewing official may be assisted by one or more of the official's employees or consultants in assessing and weighing the scientific and technical evidence and other information submitted by the appellant and respondent on the reasons for the suspension and proposed revocation.

### Section 16.3 Are there any limitations on issues subject to review?

The scope of review shall be limited to the facts relevant to any suspension or proposed revocation, the necessary interpretations of those facts, the relevant Mandatory Guidelines for Federal Workplace Drug Testing Programs, and other relevant law. The legal validity of these Guidelines shall not be subject to review under these procedures.

### Section 16.4 Who represents the parties?

The appellant's request for review shall specify the name, address, and telephone number of the appellant's representative. In its first written submission to the reviewing official, the respondent shall specify the name, address, and telephone number of the respondent's representative.

### Section 16.5 When must a request for informal review be submitted?

(a) Within 30 days of the date of the notice of the suspension or proposed revocation, the appellant must submit a written request to the reviewing official seeking review, unless some other time period is agreed to by the parties. A copy must also be sent to the respondent. The request for review must include a copy of the notice of suspension or proposed revocation, a brief statement of why the decision to suspend or propose revocation is wrong, and the appellant's request for an oral presentation, if desired.

(b) Within 5 days after receiving the request for review, the reviewing official will send an acknowledgment and advise the appellant of the next steps. The reviewing official will also send a copy of the acknowledgment to the respondent.

#### Section 16.6 What is an abeyance agreement?

Upon mutual agreement of the parties to hold these procedures in abeyance, the reviewing official will stay these procedures for a reasonable time while the laboratory or IITF attempts to regain compliance with the Guidelines or the parties otherwise attempt to settle the dispute. As part of an abeyance agreement, the parties can agree to extend the time period for requesting review of the suspension or proposed revocation. If abeyance begins after a request for review has been filed, the appellant shall notify the reviewing official at the end of the abeyance period advising whether the dispute has been resolved. If the dispute has been resolved, the request for review will be dismissed. If the dispute has not been resolved, the review procedures will begin at the point at which they were interrupted by the abeyance agreement with such modifications to the procedures as the reviewing official deems appropriate.

#### Section 16.7 What procedures are used to prepare the review file and written argument?

The appellant and the respondent each participate in developing the file for the reviewing official and in submitting written arguments. The procedures for development of the review file and submission of written argument are:

(a) Appellant's Documents and Brief. Within 15 days after receiving the acknowledgment of the request for review, the appellant shall submit to the reviewing official the following (with a copy to the respondent):

(1) A review file containing the documents supporting appellant's argument, tabbed and organized chronologically, and accompanied by an index identifying each document. Only essential documents should be submitted to the reviewing official.

(2) A written statement, not to exceed 20 double-spaced pages, explaining why respondent's decision to suspend or propose revocation of appellant's certification is wrong (appellant's brief).

(b) Respondent's Documents and Brief. Within 15 days after receiving a copy of the

acknowledgment of the request for review, the respondent shall submit to the reviewing official the following (with a copy to the appellant):

(1) A review file containing documents supporting respondent's decision to suspend or revoke appellant's certification to perform drug testing, which is tabbed and organized chronologically, and accompanied by an index identifying each document. Only essential documents should be submitted to the reviewing official.

(2) A written statement, not exceeding 20 double-spaced pages in length, explaining the basis for suspension or proposed revocation (respondent's brief).

(c) Reply Briefs. Within 5 days after receiving the opposing party's submission, or 20 days after receiving acknowledgment of the request for review, whichever is later, each party may submit a short reply not to exceed 10 double-spaced pages.

(d) Cooperative Efforts. Whenever feasible, the parties should attempt to develop a joint review file.

(e) Excessive Documentation. The reviewing official may take any appropriate step to reduce excessive documentation, including the return of or refusal to consider documentation found to be irrelevant, redundant, or unnecessary.

#### Section 16.8 When is there an opportunity for oral presentation?

(a) Electing Oral Presentation. If an opportunity for an oral presentation is desired, the appellant shall request it at the time it submits its written request for review to the reviewing official. The reviewing official will grant the request if the official determines that the decision-making process will be substantially aided by oral presentations and arguments. The reviewing official may also provide for an oral presentation at the official's own initiative or at the request of the respondent.

(b) Presiding Official. The reviewing official or designee will be the presiding official responsible for conducting the oral presentation.

(c) Preliminary Conference. The presiding official may hold a prehearing conference (usually a telephone conference call) to consider any of the following: simplifying and clarifying issues, stipulations and admissions, limitations on evidence and witnesses that will be presented at the hearing, time allotted for each witness and the hearing altogether, scheduling the hearing, and any other matter that will assist in the review process. Normally, this conference will be conducted informally and off the record; however, the presiding official may, at their discretion, produce a written document summarizing the conference or transcribe the conference, either of which will be made a part of the record.

(d) Time and Place of the Oral Presentation. The presiding official will attempt to schedule the oral presentation within 30 days of the date the appellant's request for review is received or within 10 days of submission of the last reply brief, whichever is later. The oral presentation will be held at a time and place determined by the presiding official following consultation with the parties.

(e) Conduct of the Oral Presentation.

(1) General. The presiding official is responsible for conducting the oral presentation. The presiding official may be assisted by one or more of the official's employees or consultants in conducting the oral presentation and reviewing the evidence. While the oral presentation will be kept as informal as possible, the presiding official may take all necessary steps to ensure an orderly proceeding.

(2) Burden of Proof/Standard of Proof. In all cases, the respondent bears the burden of proving by a preponderance of the evidence that its decision to suspend or propose revocation is appropriate. The appellant, however, has a responsibility to respond to the respondent's allegations with evidence and argument to show that the respondent is wrong.

(3) Admission of Evidence. The Federal Rules of Evidence do not apply and the presiding official will generally admit all testimonial evidence unless it is clearly irrelevant, immaterial, or unduly repetitious. Each party may make an opening and closing statement, may

present witnesses as agreed upon in the prehearing conference or otherwise, and may question the opposing party's witnesses. Since the parties have ample opportunity to prepare the review file, a party may introduce additional documentation during the oral presentation only with the permission of the presiding official. The presiding official may question witnesses directly and take such other steps necessary to ensure an effective and efficient consideration of the evidence, including setting time limitations on direct and cross-examinations.

(4) Motions. The presiding official may rule on motions including, for example, motions to exclude or strike redundant or immaterial evidence, motions to dismiss the case for insufficient evidence, or motions for summary judgment. Except for those made during the hearing, all motions and opposition to motions, including argument, must be in writing and be no more than 10 double-spaced pages in length. The presiding official will set a reasonable time for the party opposing the motion to reply.

(5) Transcripts. The presiding official shall have the oral presentation transcribed and the transcript shall be made a part of the record. Either party may request a copy of the transcript and the requesting party shall be responsible for paying for its copy of the transcript.

(f) Obstruction of Justice or Making of False Statements. Obstruction of justice or the making of false statements by a witness or any other person may be the basis for a criminal prosecution under 18 U.S.C. 1505 or 1001.

(g) Post-hearing Procedures. At their discretion, the presiding official may require or permit the parties to submit post-hearing briefs or proposed findings and conclusions. Each party may submit comments on any major prejudicial errors in the transcript.

Section 16.9 Are there expedited procedures for review of immediate suspension?

(a) Applicability. When the Secretary notifies an HHS-certified laboratory or IITF in writing that its certification to perform drug testing has been immediately suspended, the appellant may request an expedited review of the suspension and any proposed revocation. The appellant must submit this request in writing to the reviewing official within 3 days of the date the HHS-certified laboratory or IITF received notice of the suspension. The request for review must include a copy of the suspension and any proposed revocation, a brief statement of why the decision to suspend and propose revocation is wrong, and the appellant's request for an oral presentation, if desired. A copy of the request for review must also be sent to the respondent.

(b) Reviewing Official's Response. As soon as practicable after the request for review is received, the reviewing official will send an acknowledgment with a copy to the respondent.

(c) Review File and Briefs. Within 7 days of the date the request for review is received, but no later than 2 days before an oral presentation, each party shall submit to the reviewing official the following:

(1) A review file containing essential documents relevant to the review, which is tabbed, indexed, and organized chronologically; and

(2) A written statement, not to exceed 20 double-spaced pages, explaining the party's position concerning the suspension and any proposed revocation. No reply brief is permitted.

(d) Oral Presentation. If an oral presentation is requested by the appellant or otherwise granted by the reviewing official, the presiding official will attempt to schedule the oral presentation within 7-10 days of the date of appellant's request for review at a time and place determined by the presiding official following consultation with the parties. The presiding official may hold a prehearing conference in accordance with Section 16.8(c) and will conduct the oral presentation in accordance with the procedures of Sections 16.8(e), (f), and (g).

(e) Written Decision. The reviewing official shall issue a written decision upholding or denying the suspension or proposed revocation and will attempt to issue the decision within 7-10 days of the date of the oral presentation or within 3 days of the date on which the transcript is

received or the date of the last submission by either party, whichever is later. All other provisions set forth in Section 16.14 will apply.

(f) Transmission of Written Communications. Because of the importance of timeliness for these expedited procedures, all written communications between the parties and between either party and the reviewing official shall be by fax, secured electronic transmissions, or overnight mail.

#### Section 16.10 Are any types of communications prohibited?

Except for routine administrative and procedural matters, a party shall not communicate with the reviewing or presiding official without notice to the other party.

#### Section 16.11 How are communications transmitted by the reviewing official?

(a) Because of the importance of a timely review, the reviewing official should normally transmit written communications to either party by fax, secured electronic transmissions, or overnight mail in which case the date of transmission or day following mailing will be considered the date of receipt. In the case of communications sent by regular mail, the date of receipt will be considered 3 days after the date of mailing.

(b) In counting days, include Saturdays, Sundays, and federal holidays. However, if a due date falls on a Saturday, Sunday, or federal holiday, then the due date is the next federal working day.

#### Section 16.12 What are the authority and responsibilities of the reviewing official?

In addition to any other authority specified in these procedures, the reviewing official and the presiding official, with respect to those authorities involving the oral presentation, shall have the authority to issue orders; examine witnesses; take all steps necessary for the conduct of an orderly hearing; rule on requests and motions; grant extensions of time for good reasons; dismiss for failure to meet deadlines or other requirements; order the parties to submit relevant information or witnesses; remand a case for further action by the respondent; waive or modify these procedures in a specific case, usually with notice to the parties; reconsider a decision of the reviewing official where a party promptly alleges a clear error of fact or law; and to take any other action necessary to resolve disputes in accordance with the objectives of these procedures.

#### Section 16.13 What administrative records are maintained?

The administrative record of review consists of the review file; other submissions by the parties; transcripts or other records of any meetings, conference calls, or oral presentation; evidence submitted at the oral presentation; and orders and other documents issued by the reviewing and presiding officials.

#### Section 16.14 What are the requirements for a written decision?

(a) Issuance of Decision. The reviewing official shall issue a written decision upholding or denying the suspension or proposed revocation. The decision will set forth the reasons for the decision and describe the basis therefore in the record. Furthermore, the reviewing official may remand the matter to the respondent for such further action as the reviewing official deems appropriate.

(b) Date of Decision. The reviewing official will attempt to issue their decision within 15 days of the date of the oral presentation, the date on which the transcript is received, or the date of the last submission by either party, whichever is later. If there is no oral presentation, the decision will normally be issued within 15 days of the date of receipt of the last reply brief.

Once issued, the reviewing official will immediately communicate the decision to each party.

(c) Public Notification. If the suspension and proposed revocation are upheld, the revocation will become effective immediately and the public will be notified by publication of a notification in the **Federal Register**. If the suspension and proposed revocation are denied, the revocation will not take effect and the suspension will be lifted immediately. Public notification will be given by publication in the **Federal Register**.

Section 16.15 Is there a review of the final administrative action?

Before any legal action is filed in court challenging the suspension or proposed revocation, respondent shall exhaust administrative remedies provided under this subpart, unless otherwise provided by Federal Law. The reviewing official's decision, under Section 16.9(e) or 16.14(a) constitutes final agency action and is ripe for judicial review as of the date of the decision.